

IN THE UNITED STATES DISTRICT COURT  
FOR THE MIDDLE DISTRICT OF ALABAMA  
NORTHERN DIVISION

CHARLES HICKS (AIS# 246241),

Plaintiff,

v.

ALABAMA DEPARTMENT OF  
CORRECTIONS, et al.

Defendants.

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CIVIL ACTION NO.

1:06cv1033-WKW

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**SPECIAL REPORT OF DEFENDANTS**  
**PRISON HEALTH SERVICES, INC. AND DR. CORBIER**

COME NOW Defendants, Prison Health Services (identified in the plaintiff's Complaint as Prison Medical Services) (hereinafter "PHS") and Paul Corbier, M.D., in response to this Honorable Court's order and presents the following Special Report with regard to this matter:

**I. INTRODUCTION**

The plaintiff/prisoner in this case, Charles Hicks (AIS# 246241), has been incarcerated since April 2006 at various facilities in the State of Alabama. Regarding this particular complaint, Hicks alleges his place of present confinement is the Frank Lee Youth Center, Deatsville, Alabama.

On or about October 19, 2006, Hicks filed a complaint against Defendant PHS and others surrounding the allegedly inadequate medical care received by him as an incarcerated prisoner with the Alabama Department of Corrections. That case, filed in the United States District Court for Middle District of Alabama, is styled 2:06cv-990-MWF. In that case, Hicks complained about inadequate medical care and cited multiple constitutional grounds

that he believes supported his claim of poor medical treatment. Specifically, Hicks asserted the following “claims” in that lawsuit:

1. Hicks contended he was provided inadequate medical treatment concerning complications from diabetes, specifically in his left leg.
2. Hicks asserted that he filed “numerous grievances” pertaining to his condition, even though such grievances cannot be located.
3. The prison physician, Dr. Paul Corbier, demonstrated deliberate indifference by failing to quickly obtain diabetic shoes.

Defendant PHS is the company currently contracting with the Department of Corrections to provide healthcare services to inmates within the State. Hicks sought an unknown amount in damages.

In the initial case file, Defendant PHS filed a properly supported Special Report, including a certified copy of Hicks’ medical records [Exhibit “A”], an affidavit from Dr. Paul Corbier [Exhibit “B”], and an affidavit from Darryl Ellis [Exhibit “C”], along with other specific exhibits. This material provided indisputable evidence to show that Hicks (1) failed to follow required administrative procedures pursuant to the Prison Litigation Reform Act of 1995, 42 U.S.C. 1999(e), et seq. (“PRLA”) and (2) was provided appropriate medical care for his complaints at all times. In the case before this Court, Hicks reiterates those very same claims albeit in the context of a second, separate lawsuit. There is no distinguishable difference between Hicks’ initial complaint, a copy of which is marked hereto as Exhibit “D” and the Complaint filed in this case, a copy of which is attached hereto as Exhibit “E.”

Defendant PHS has already undertaken a review of Hicks’ claims and determined that adequate medical care was provided for him at all times. In addition, PHS has determined that Hicks, again, failed to follow required administrative procedures under the PRLA.

Thirdly, Hicks violated the principles of *res judicata* by filing two separate lawsuits involving identical claims against the same defendants arising out of the same set of facts.

## **II. NARRATIVE SUMMARY OF FACTS**

Hicks claims to have been incarcerated with the Alabama Department of Corrections since April 2006. Hicks claims that he has been provided inadequate medical treatment concerning complications from diabetes, specifically in his left leg. In his complaint, Hicks asserts that he has filed “numerous grievances” pertaining to his condition and currently claims to be in constant pain.

Hicks filed a sick call request on August 2, 2006, indicating a need to see a doctor “real bad because I am not feeling well at all.” [Exhibit “F”]. Hicks complained of feeling very weak and reported his diabetic condition to the treating nurses. He was instructed to notify PHS physicians if his glucose level was less than 60. Hicks returned to sick call on August 23, 2006, at which time he was provided medication from the prison’s stock and was ordered to return if his condition worsened. [Exhibit “G” – 08/23/06 note]. Hicks also complained again on September 12, 2006, requesting that he get all medications KOP. During the physical exam, his blood pressure was reported as 140/90 and Hicks exhibited good range of motion in his left arm. No swelling was noted in either his right or left shoulder, despite complaints from Hicks concerning pain in these areas.

On September 14, 2006, Hicks completed a request for diabetic shoes. On exam, his ankles were noted as being swollen due to poor circulation. As a result of this exam, he was referred to Dr. Paul Corbier. Dr. Corbier’s progress notes indicate that on September 22, 2006, Hicks reported for a follow-up sick call. He again complained of pain in his left neck

and chills for the past six (6) days. As for his diabetic condition and problems with his feet, Dr. Corbier's notes indicate that Hicks was presently wearing TED hose to treat for this condition. [Exhibit "A"].

On October 2, 2006, Hicks returned for additional treatment of his neck pain. Dr. Corbier noted a previous left posterior cervical lymph node enlargement and provided medication for this condition. Hicks also complained of persistent lower extremity pain associated with walking. Dr. Corbier ordered additional medication as well as a formal request for diabetic shoes.

On October 13, 2006, Hicks returned for follow-up treatment with Dr. Corbier. He expressed concerns about pain in his left leg and again requested special shoes for elephantiasis. Corbier noted Hicks' left leg had marked swelling and bruising and, as a result, Corbier increased his diuretic therapy and again filled out the appropriate forms for diabetic shoes.

On October 25, 2006, Hicks received a venous doplar assessment on both of his legs after that procedure had been requested. At that time, he voiced no complaints about his medical condition, but did state for the first time that he wanted an attorney contacted regarding the medical treatment for his legs. Corbier instructed Hicks to return in 10 days to discuss the venous report results.

On November 3, 2006, Hicks returned to discuss the follow-up test results. Hicks was informed that there was no evidence of deep vein thrombosis ("DVT") in his leg, a positive development given his diabetic condition. [Exhibit "A"]. Corbier noted severe chronic swelling with a history of diabetes and hypertension and ordered Hicks to inspect his leg

twice daily. [Exhibit "A"]. A cane and support stockings were provided with instructions to Hicks to keep his legs elevated.

All of Mr. Hicks' medical complaints, with specific emphasis on those relating to his diabetic condition, have been evaluated and treated in a timely and appropriate fashion. [Exhibit "A", Exhibit "B"]. Hicks has been seen and evaluated by medical and nursing staff and has even been referred to outside care providers and provided appropriate care when medical conditions warranted such a referral, including outside diagnostic testing pertaining to a possible diagnosis of DVT. All of those outside tests were negative.

Both the Frank Lee Youth Center and Staton Correctional have in place a set of grievance procedures specifically related to health complaints. [Exhibit "H"]. It is required that inmates file grievances concerning healthcare services in order to facilitate a prompt review of the medical records. [Id.]. If necessary, the inmate is then interviewed and a review of the grievance occurs within three (3) days after the patient has filed the grievance. [Id.]. If the grievance cannot be resolved to the inmate's satisfaction, the prisoner may request an appeal in which case his initial written grievance will be reviewed through the facility review process and answered within five (5) days. [Id.]. It is undisputed that Hicks failed to follow the grievance procedures in place prior to filing this particular complaint in the United States District Court for the Middle District of Alabama.

At all times, the Defendants have exercised the same degree of care, skill, and diligence as other similarly situated healthcare providers would have exercised under the same or similar conditions. [Exhibits "A", "B", "C", "F", "G"]. In other words, the appropriate standard of care has been adhered to at all times in providing medical care, evaluation, and treatment to this inmate. Id.

At no time has this Defendant denied Mr. Hicks any needed medical treatment, nor have they ever acted with deliberate indifference to any serious medical needs of this prisoner. At all times, Mr. Hicks' medical complaints and conditions have been addressed as promptly as possible under the circumstances.

### **III. DEFENSES**

The Defendants assert the following defenses to the Plaintiff's claims:

1. The Plaintiff/prisoner failed to comply with the mandatory requirements of the Prison Litigation Reform Act of 1995, 42 U.S.C. §1997(e), et seq. ("PLRA") and the PLRA directly applies to require that this matter be dismissed with prejudice for failing to comply with the terms and conditions of grievance procedures concerning medical issues.
2. The Defendants deny each and every material allegation contained in the Plaintiff's Complaint and demand strict proof thereof.
3. The Defendants plead not guilty to the charges in the Plaintiff's Complaint.
4. The Plaintiff's Complaint, as amended, fails to state a claim against the Defendants for which relief can be granted.
5. The Defendants affirmatively deny any and all alleged claims by the Plaintiff.
6. The Plaintiff is not entitled to any relief requested in the Complaint, as amended.
7. The Defendants plead the defense of qualified immunity and avers that the actions taken by the Defendants were reasonable and in good faith with reference to clearly established law at the time of the incidents complained of by the Plaintiff.

8. The Defendants are entitled to qualified immunity and it is clear from the face of the Complaint, as amended, that the Plaintiff has not alleged specific facts indicating that the Defendants have violated any clearly established constitutional right.

9. The Defendants cannot be held liable on the basis of respondeat superior, agency, or vicarious liability theories.

10. The Plaintiff is not entitled to any relief under 42 U.S.C. § 1983.

11. The allegations contained in the Plaintiff's Complaint, as amended, against the Defendants sued in their individual capacities, fails to comply with the heightened specificity requirement of Rule 8 in § 1983 cases against persons sued in their individual capacities. See Oladeinde v. City of Birmingham, 963 F.2d 1481, 1485 (11th Cir. 1992); Arnold v. Board of Educ. Of Escambia County, 880 F.2d 305, 309 (11th Cir. 1989).

12. The Defendants plead all applicable immunities, including, but not limited to qualified, absolute, discretionary function immunity, and state agent immunity.

13. The Defendants aver that they were at all times acting under color of state law and, therefore, they are entitled to substantive immunity under the law of the State of Alabama.

14. The Defendants plead the general issue.

15. This Court lacks subject matter jurisdiction due to the fact that even if the Plaintiff's allegations should be proven, the allegations against the Defendants would amount to mere negligence which is not recognized as a deprivation of the Plaintiff's constitutional rights. See Rogers v. Evans, 792 F.2d 1052 (11th Cir. 1986).

16. The Plaintiff's claims against the Defendants in their official capacities are barred by the Eleventh Amendment to the United States Constitution.

17. Alabama law provides tort and other remedies for the allegations made by the Plaintiff herein and such remedies are constitutionally adequate.

18. The Defendants plead the defense that at all times in treating Plaintiff they exercised the same degree of care, skill, and diligence as other physicians and nursing staff would have exercised under similar circumstances and that at no time did they act toward the Plaintiff with deliberate indifference to a serious medical need.

19. The Defendants plead the affirmative defense that the Plaintiff's Complaint, as amended, fails to contain a detailed specification and factual description of the acts and omissions alleged to render them liable to the Plaintiff as required by § 6-5-551 of the Ala. Code (1993).

20. The Defendants plead the affirmative defenses of contributory negligence and assumption of the risk.

21. The Defendants plead the affirmative defense that Plaintiff's damages, if any, were the result of an independent, efficient, and/or intervening cause.

22. The Defendants plead the affirmative defense that they are not responsible for the policies and procedures of the Alabama Department of Corrections.

23. The Defendants plead the affirmative defense that the Plaintiff has failed to mitigate his own damages.

24. The Defendants plead the affirmative defense that they are not guilty of any conduct which would justify the imposition of punitive damages against it and that any such award would violate the United States Constitution.

25. The Defendants adopt and assert all defenses set forth in the Alabama Medical Liability Act § 6-5-481, et seq., and § 6-5-542, et seq.



26. The Plaintiff has failed to comply with 28 U.S.C. § 1915 with respect to the requirements and limitations inmates must follow in filing in forma pauperis actions in federal court.

27. Pursuant to 28 U.S.C. § 1915 A, this Court is requested to screen and dismiss this case, as soon as possible, either before or after docketing, as this case is frivolous or malicious, fails to state a claim upon which relief may be granted, or seeks money damages from the Defendants who are state officers entitled to immunity as provided for in 42 U.S.C. § 1997 (e)(c).

28. The Defendants assert that the Plaintiff's Complaint, as amended, is frivolous and filed in bad faith solely for the purpose of harassment and intimidation and requests this Court pursuant to 42 U.S.C. § 1988 to award Defendants reasonable attorney's fees and costs incurred in the defense of this case.

29. The Plaintiff's claims are moot because the events which underlie the controversy have been resolved. See Marie v. Nickels, 70 F., Supp. 2d 1252 (D. Kan. 1999).

#### **IV. ARGUMENT**

**A. Because Inmate Hicks Failed to Follow the Required Grievance Procedures for Assessing Medical Complaints Prior to Filing His Lawsuit, the Prison Litigation Reform Act of 1995 Requires the Immediate Dismissal, with Prejudice, of His Complaint.**

With the explosion of prisoner cases becoming epidemic, Congress passed the Prison Litigation Reform Act of 1995 in an effort to control frivolous prisoner litigation. The Act is wide ranging and contains multiple, mandatory provisions that require the dismissal of complaints identical to that asserted by Mr. Hicks.

The PLRA defines a prisoner as follows:

As used in this section, the term “prisoner” means any person incarcerated or detained in any facility who is accused of, convicted of, sentenced for, or adjudicated delinquent for, violations of criminal law or the terms and conditions of parole, probation, pretrial release, or diversionary program. 42 U.S.C. §1997e(h).

Because Hicks admits to being incarcerated in his complaint, he meets the definition of “prisoner” as defined by the PLRA. See Boyd v. Corrections Corporation of America, 380 F.3d 989 (6<sup>th</sup> Cir. 2004).

The crux of the PLRA requires a prisoner to exhaust all internal, administrative remedies prior to filing suit. The PLRA requires that the Court on its motion or the motion of a defendant dismiss any action with respect to prisoner conditions or medical treatment upon failure to exhaust these remedies. 42 U.S.C. §1997e(a). This provision states the following:

**(a) Applicability of Administrative Remedies.**

No action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted. (emphasis added).

**(b) Failure of State to Adopt or Adhere to Administrative Grievance Procedure.**

The failure of a State to adopt or adhere to an administrative grievance procedure shall not constitute the basis for an action under 1997a or 1997c of this Title.

**(c) Dismissal**

The Court shall on its own motion or on the motion of a party dismiss any action brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility if the court is satisfied that the action is frivolous, malicious, fails to state a claim upon which relief can be granted, or seeks monetary relief from a defendant who is immune from such relief.

42 U.S.C. § 1997e(a)

“Administrative remedies” pursuant to this Act constitute prison or jail grievance procedures such as those identified in this Special Report. Before filing suit, the prison/plaintiff must submit his claim through this procedure and the grievance must address the specific issue upon which the suit is based. Failure to strictly follow these procedures requires dismissal of the action. Even if the prisoner/plaintiff has no knowledge regarding the existence of the procedures, this does not relieve the requirement. See Zolicoffer v. Scott, 55 F. Supp. 2d 1372 (N.D. Ga. 1999), affirmed without opinion (252 F.3d 440 (11<sup>th</sup> Cir. 2001)).

It is undisputed that Hicks failed to follow the appropriate administrative procedures associated with his claim for inadequate medical care. [Exhibit “C” – Affidavit Darryl Ellis]. Because Hicks failed to follow internal procedures concerning these grievances, his claim must be dismissed with prejudice for failing to comply with these mandatory administrative remedies. Woodford v. NGO, 126 S. Ct. 2378, 165 L.Ed.2d 368 (2006).

The Woodford case is extremely instructive because the United States Supreme Court took the opportunity to clarify issues concerning the Prison Litigation Reform Act. In Woodford, a California state prisoner challenged a disciplinary act but did so in an untimely manner, violating California’s Prison Grievance System. Subsequently, the prisoner sued the system in federal court, but the district court granted the Department’s Motion to Dismiss, stating the prisoner had not fully exhausted his administrative remedies, pursuant to the Prison Litigation Reform Act. On appeal, the Ninth Circuit reversed, claiming that because no administrative remedies remained available to the prisoner, he had “not exhausted them” amongst other reasons.

On appeal, the United States Supreme Court reversed the Ninth Circuit and affirmed the dismissal of the prisoner's complaint. The Court's opinion focused extensively on the "exhaustion" of available remedies and concluded that whether procedural deficiencies existed or whether a prisoner is poorly educated and unfamiliar with such proceedings, it is a requirement that administrative remedies be followed prior to litigation ensuing in federal court. *Id.* At 2387, 2388, 2390, 2392-2393.

**B. The Plaintiff has failed to prove that the Defendants acted with deliberative indifference to any serious medical need.**

A court may dismiss a complaint for failure to state a claim if it is clear that no relief could be granted under any set of facts that could be proven consistent with the allegations in the complaint. *Romero v. City of Clanton*, 220 F. Supp. 2d 1313, 1315 (M.D. Ala., 2002), (citing, *Hishon v. King & Spalding*, 467 U.S. 69, 73, (1984). "Procedures exist, including Federal Rule of Civil Procedure 7(a), or Rule 12(e), whereby the trial court may "protect the substance of qualified immunity," *Shows v. Morgan*, 40 F. Supp. 2d 1345, 1358 (M.D. Ala., 1999). A careful review of Hicks' medical records reveals that he has been given appropriate medical treatment at all times. (See Exhibits "A" & "B"). All of the allegations contained within Hicks' Complaint, as amended, are either inconsistent with his medical records, or are claims for which no relief may be granted. (*Id.*) Therefore, Hicks' claims against the Defendants are due to be dismissed.

In order to state a cognizable claim under the Eighth Amendment, Hicks must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. See *Estelle v. Gamble*, 429 U.S. 97, 106 (U.S. 1976); *McElligott v. Foley*, 182 F.3d 1248, 1254 (11th Cir. 1999); *Palermo v. Corr. Med. Servs.*, 148 F. Supp. 2d 1340, 1342 (S.D.

Fla. 2001). In order to prevail, Hicks must allege and prove that he suffered from a serious medical need, that the Defendants were deliberately indifferent to his needs, and that he suffered harm due to deliberate indifference. See Marsh v. Butler County, 268 F.3d 1014, 1058 (11th Cir. 2001) and Palermo, 148 F. Supp. 2d at 1342. “Neither inadvertent failure to provide adequate medical care nor a physician's negligence in diagnosing or treating a medical condition states a valid claim of medical mistreatment under the Eighth Amendment.” Id. (citations omitted).

Not every claim by a prisoner that medical treatment has been inadequate states an Eighth Amendment violation. Alleged negligent conduct with regard to inmates’ serious medical conditions does not rise to the level of a constitutional violation. Alleged medical malpractice does not become a constitutional violation merely because the alleged victim is a prisoner. See Estelle, 429 U.S. at 106, McElligott, 182 F.3d at 1254, Hill, 40 F.3d 1176, 1186 (11<sup>th</sup> Cir. 1994), Palermo, 148 F. Supp. 2d at 1342. Further, a mere difference of opinion between an inmate and the physician as to treatment and diagnosis cannot give rise to a cause of action under the Eighth Amendment. Estelle, 429 U.S. at 106-108.

The Defendants may only be liable if they had knowledge of Hicks’ medical condition, Hill, 40 F. 3d at 1191, and acted intentionally or recklessly to deny or delay access to his care, or to interfere with treatment once prescribed. Estelle, 429 U.S. at 104-105. Obviously, Hicks cannot carry his burden. The evidence submitted with this Special Report clearly shows that the Defendants did not act intentionally or recklessly to deny or delay medical care, or to interfere with any treatment which was prescribed or directed. The evidence demonstrates, to the contrary, that appropriate standards of care were followed at all times.

(Id.) These facts clearly disprove any claim that the Defendants acted intentionally or recklessly to deny treatment or care.

The Defendants are, further, entitled to qualified immunity from all claims asserted by Hicks in this action. There is no argument that the Defendants were not acting within the scope of their discretionary authority. See Eubanks v. Gerwen, 40 F. 3d 1157, 1160 (11<sup>th</sup> Cir. 1994); see also Jordan v. Doe, 38 F. 3d 1559, 1566 (11<sup>th</sup> Cir. 1994). Because the Defendants have demonstrated that they were acting within the scope of their discretionary authority, the burden shifts to Hicks to show that the Defendants violated clearly established law based upon objective standards. Eubanks, 40 F. 3d at 1160. The Eleventh Circuit requires that before the Defendants' actions can be said to have violated clearly established constitutional rights, Hicks must show that the right allegedly violated was clearly established in a fact-specific, particularized sense. Edwards v. Gilbert, 867 F.2d 1271, 1273 (11<sup>th</sup> Cir. 1989), aff'd in pertinent part, rev'd in part on other grounds, sub nom., Edwards v. Okaloosa County, 5 F. 3d 1431 (11<sup>th</sup> Cir. 1989).

The Eleventh Circuit further requires that the inquiry be fact specific, and that officials will be immune from suit if the law with respect to their actions was unclear at the time the cause of action arose, or if a reasonable person could have believed that their actions were lawful in light of clearly established law and information possessed by the individual. See Brescher v. Von Stein, 904 F.2d 572, 579 (11th Cir. 1990) (quoting, Anderson v. Creighton, 483 U.S. 635, 640, (U. S. 1987)). The question that must be asked is whether the state of the law in 2006 gave the Defendants fair warning that their alleged treatment of Hicks was unconstitutional. Hope v. Pelzer, 536 U.S. 730, 741 (U.S. 2002).

Therefore, to defeat summary judgment, Hicks must be able to point to cases with “materially similar” facts, within the Eleventh Circuit, that would alert the Defendants to the fact that their practice or policy violates his constitutional rights. See Hansen v. Soldenwagner, 19 F.3d 573, 576 (11th Cir. 1994). In order for qualified immunity to be defeated, preexisting law must “dictate, that is truly compel (not just suggest or allow or raise a question about), the conclusion for every like-situated, reasonable government agent that what the defendant is doing violates federal law in the circumstances.” Lassiter v. Alabama A & M Univ., Bd. of Trustees, 28 F. 3d 1146, 1151 (11<sup>th</sup> Cir. 1994). The Defendants submit that there is no case law from the United States Supreme Court, the Eleventh Circuit Court of Appeals, or District Courts sitting within the Eleventh Circuit showing that, under the facts of this case, it was clearly established that these alleged actions violated Hicks’ constitutional rights. All of Hicks’ medical needs have been addressed or treated. (See Exhibits “A” & “B”). The Defendants have provided Hicks with appropriate medical care at all times and he has received appropriate nursing care as indicated for treatment of his condition.

## **V. CONCLUSION**

Charles Hicks has filed two complaints arising out of the same set of facts against the same Defendant. Defendant PHS has previously filed a Special Report and for purposes of this case, has filed a virtually identical Special Report dealing with Mr. Hicks’ second lawsuit since the claims are identical. On all accounts, Mr. Hicks has received appropriate medical treatment for his diabetic condition and has received immediate medical treatment when those claims have been brought to the attention of PHS employees. Without question,

Hicks' complaints do not rise to the high standard of deliberate indifference to a serious medical need.

Hicks also failed to follow internal grievance procedures, thereby violating the Prison Litigation Reform Act that requires prisoners to adhere to internal procedures prior to initiating litigation. Recent United States Supreme Court cases require dismissal of prisoner cases when this occurs.

Finally, the principles of res judicata prevent Mr. Hicks from filing an identical lawsuit arising out of the same facts and transactions against the same Defendants in a separate court. Mr. Hicks' claim is currently pending in federal court in a case styled Charles Hicks v. Alabama Department of Corrections; 2:06cv-990-MWF, United States District Court – Middle District of Alabama.

For the reasons set out above, the Plaintiff has not established a right to pursue litigation against the Defendants and has failed to establish a deliberate indifference to a serious medical need. At best, he has filed the identical lawsuit in two separate courts, warranting the immediately dismissal of this particular case.

Respectfully submitted,

/s/ PAUL M. JAMES, JR.  
Alabama State Bar Number JAM017  
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**CERTIFICATE OF SERVICE**

I hereby certify that a copy of the above and foregoing has been served by U.S. Mail  
this the 2nd day of March, 2007, to:

Charles Hicks (AIS# 246241)  
P. O. Box 220410  
Deatsville, AL 36022

The Clerk of Court, using the CM/ECF system will send notification of this filing to the  
following:

Greg Biggs, Esq.  
Assistant Attorney General  
Alabama Department of Corrections  
Legal Division  
P. O. Box 301501  
Montgomery, AL 36130

/s/ PAUL M. JAMES, JR. (JAM017)  
Attorney for Defendants Prison Health  
Services, Inc. and Dr. Corbier

# **EXHIBIT A**

## AFFIDAVIT

STATE OF ALABAMA )

\_\_\_\_\_) COUNTY )

I, Tommie Ellerbee, hereby certify and affirm that I am a MEDICAL CLERK, at STATION Healthcare; that I am one of the custodians of medical records at this institution; that the attached documents are true, exact, and correct photocopies of certain medical records maintained here in the institution medical file of one Hicks, Charles, AIS# 246241; and that I am over the age of twenty-one years and am competent to testify to the aforesaid documents and matters stated therein.

I further certify and affirm that said documents are maintained in the usual and ordinary course of business at \_\_\_\_\_; and that said documents (and the entries therein) were made at, or reasonably near, the time that by, or from information transmitted by, a person with knowledge of such acts, events, and transactions referred to therein are said to have occurred.

This, I do hereby certify and affirm to on this the 30 day of November, 2006

SWORN TO AND SUBSCRIBED BEFORE ME THIS THE  
30 Day of November, 2006

Ann Marie Latrine  
Notary Public

12/06/2008  
My Commission Expires



## PHYSICIANS' ORDERS

NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Last Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Fourth Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Third Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Second Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: Hicks, Charles (C)	DIAGNOSIS DM
D.O.B. 11/26/	- NGD1C 001453
ALLERGIES: MKA	- 210349 Puffin Faby
	UP in house
	- BS 1 B17 x 100 days
Use First Date 11/20/06 1505	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED

MEDICAL RECORDS COPY



## PHYSICIANS' ORDERS

NAME: Hicks, Charles 246241 D.O.B. 11/12/161 ALLERGIES: NKDA Use Last Date 12/20/16 1505	① DIAGNOSIS (If Chg'd) men female EC ASA 325mg tpo daily x 100 days Cefixime 10mg tpo daily x 100 days Nexavar 40mg tpo QWS x 100 days NCT 25mg tpo QAM x 100 days Usunaprel 20mg tpo BID x 100 days <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles 246241 D.O.B. 11/12/161 ALLERGIES: NKDA Use Fourth Date 11/7/08	DIAGNOSIS (If Chg'd) - 1 Month PCU - 1 B C BFD x 120 days - 2000 ADA diabetic diet - Aldactone 50mg tpo QD x 90 days <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles 246241 D.O.B. 11/12/161 ALLERGIES: NKDA Use Third Date 11/3/06	DIAGNOSIS (If Chg'd) ① ASA 81mg PO QD x 100d ② BBP x 100 DAYS <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles 246241 D.O.B. 11/12/161 ALLERGIES: NKDA Use Second Date 11/3/06	DIAGNOSIS (If Chg'd) ① A & D OINTMENT KOP x 90d ② F/U HCU IN 2-3 wks ③ No prolonged standing, FRONT OF LINE Pacifier x 180 d, CRANE & STOCKING Pacifier x 180d - VENOUS INSUFFICIENCY <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles D.O.B. / / ALLERGIES: Use First Date 10/30/06	DIAGNOSIS HCU F/U TEST RESULTS - Leg Pain <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED



## PHYSICIANS' ORDERS

NAME: Hicks, Charles 246241 7LYC D.O.B. 11/21/61 KDA ALLERGIES: Use Last Date 10/30/06	DIAGNOSIS (If Chg'd) D. Malignant 400 mg Bid X 2 days PRN pp. Dr. Corbice / Dr. Swindell Noted 10-26-06 10:30 PM - DS J. Parham <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles D.O.B. 11/21/61 ALLERGIES: NKDA Use Fourth Date 10/27/06	DIAGNOSIS (If Chg'd) BS BID x 30 days slide profile - marked peripheral edema X 60 days R. O. Corbice <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles 246241 D.O.B. 11/21/61 FLYC ALLERGIES: NKDA Use Third Date 10/25/06	DIAGNOSIS (If Chg'd) (Frank Lee Nurse) Please inform Pt. of Neg. Venous drops 10/26/06 3:20 PM R. O. Corbice <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles 246241 D.O.B. 11/21/61 FLYC ALLERGIES: NKDA Use Second Date 10/25/06 1505	DIAGNOSIS (If Chg'd) Nausea in 10 days re. Venous drops rears 11/3/06 10:50 PM R. O. Corbice <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles 246241 D.O.B. 11/21/61 ALLERGIES: NKDA Use First Date 10/20/06	DIAGNOSIS Blood sugar checks X 2 weeks Noted MSanders RN 10:50 PM 10/20/06 B. Parham <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED



## PHYSICIANS' ORDERS

NAME: <u>Hicks, Charles</u> <u>246241</u> D.O.B. <u>11/2/61</u> <u>FLYC</u> ALLERGIES: <u>NKDA</u> Use Last Date <u>10/1/06</u>	DIAGNOSIS (If Chg'd) <u>Carin 400 mg TPO BID x 2 wks</u> <u>10/1/06</u> <u>10/1/06</u> <u>10/1/06</u> <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED <u>R. P. C.</u>
NAME: <u>Hicks, Charles</u> <u>246241</u> D.O.B. <u>11/2/61</u> <u>FLYC</u> ALLERGIES: <u>NKDA</u> Use Fourth Date <u>10/1/06</u>	DIAGNOSIS (If Chg'd) <u>DM done for Diabetes shoes</u> <u>10/1/06</u> <u>10/1/06</u> <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED <u>R. P. C.</u>
NAME: <u>Hicks, Charles</u> D.O.B. <u>11/2/61</u> ALLERGIES: <u>NKDA</u> Use Third Date <u>10/1/06</u>	DIAGNOSIS (If Chg'd) <u>Schedule HCU 2 weeks</u> <u>10/1/06</u> <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED <u>R. P. C.</u>
NAME: <u>Hicks, Charles</u> <u>246241</u> D.O.B. <u>11/2/61</u> <u>FLYC</u> ALLERGIES: <u>NKDA</u> Use Second Date <u>10/2/06</u>	DIAGNOSIS (If Chg'd) <u>1) Lasix 40mg TPO QAM x 2 wks</u> <u>2) KCL 10 mg TPO QAM x 2 wks</u> <u>3)</u> <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED <u>R. P. C.</u>
NAME: <u>Hicks, Charles</u> <u>246241</u> D.O.B. <u>11/2/61</u> <u>FLYC</u> ALLERGIES: <u>NKDA</u> Use First Date <u>10/2/06</u>	DIAGNOSIS <u>⑥ Procedure day - toenail trim</u> <u>① 2000 cal ADA diet x 180 days</u> <u>② (B) LE Venous doppler (PVD)</u> <u>③ Augmentin 875mg TPO BID x 10 days</u> <u>④ May purchase diabetic shoes affor</u> <u>⑤ FU 12 wks C CRNP Mal 10/2/06</u> <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED <u>R. P. C.</u>





## PHYSICIANS' ORDERS

NAME: Hicks, Charles 246241 D.O.B. 11/2/61 ALLERGIES: NKDA Use Last Date 10/2/06	DIAGNOSIS (If Chg'd) ① Please draw DP II ASAP ② Clonidine 0.2mg PO x 1 now ③ Epsom salt + soaks QD x 14 days ④ BP ✓ QD x 14 days <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles 246241 D.O.B. 11/2/61 ALLERGIES: NKDA Use Fourth Date 9/22/06	DIAGNOSIS (If Chg'd) ① DP II ② Bacrim DS + PO BID x 10 days ③ E/U 1 yr. w/ maldet CRNP ④ 1800 cal ADA diet - error <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles D.O.B. 11/2/61 ALLERGIES: NKDA Use Third Date 9/22/06	DIAGNOSIS (If Chg'd) Keep scheduled apt 9/22/06 <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles D.O.B. 11/2/61 ALLERGIES: NKDA Use Second Date 9/15/06	DIAGNOSIS (If Chg'd) Schedule for HCU next week 9-22-06 9/15 <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks Charles 246241 D.O.B. 11/2/61 ALLERGIES: NKDA Use First Date 9/12/06	DIAGNOSIS DIC Maxipide Nort 25mg PO QD x 90 days lisinopril 20mg PO BID x 90 days BP ✓ QD x 14 days No KOP & BP Meds till further notice <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED





## PHYSICIANS' ORDERS

NAME: Hicks, Charles D.O.B. 11/02/61 246241 ALLERGIES: NKA Use Last Date 08/03/06 08/03/06	DIAGNOSIS (If Chg'd) Diabetes MD if glucose less than 60% Fasting DR IT next Lab draw p.o. Dr. Cortigan BHM and CMA <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles D.O.B. 11/2/61 7L ALLERGIES: NKA Use Fourth Date 7/12/06	DIAGNOSIS (If Chg'd) noted S. Taylor 7-12-06 D. PAR D. Short 2000 cal ADA-365 - Call pt to "pill call" line to get pink slip & phony on ADA doc list <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles D.O.B. 11/02/61 ALLERGIES: NKA Use Third Date 07/05/06	DIAGNOSIS (If Chg'd) ① HCL- chronic case IN 3 mos 9/26/06 ② HCL on next Wed. 07/13/06 Self Dr. Pearson for mail clipping ③ Check urine microalbumin in 80 days ④ Onward Clinic <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles D.O.B. 11/2/61 Bm ALLERGIES: NKA Use Second Date 7/05/06	DIAGNOSIS (If Chg'd) ① Discontinue Varotev. ② Plavix 75mg p.o. QD x 180 days ③ Fasting HbA1c in 80 days ④ Glucose (BS) check BID x 30 days ⑤ Extra lg. high high foot care <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Hicks, Charles D.O.B. 11/02/61 ALLERGIES: NKA Use First Date 5/13/06	DIAGNOSIS 1) Varotev 5 mg po qd x 180d 2) HgbA1c ~ 10 wks <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED



## PHYSICIANS' ORDERS

NAME: <u>Hicks, Charles</u> D.O.B. <u>11/2/61</u> <u>246241</u> ALLERGIES: <u>None</u> Use Last Date <u>5/19/06</u>	DIAGNOSIS (If Chg'd) <u>Trim Nails to time - notify provider to do</u> ✓  <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED <u>Dr. Santur</u>
NAME: <u>Hicks, Charles</u> D.O.B. <u>11/2/01</u> <u>246241</u> ALLERGIES: <u>None</u> Use Fourth Date <u>5/19/06</u>	DIAGNOSIS (If Chg'd) <u>CC 400s 2wks DM/HTN</u> <u>Lisinopril 10m</u> <u>Metoprolol 25/50 mg po qd x 180 days</u> ✓ <u>BBP x 3 months</u> <u>Extra blanket to allow inmate to sleep with</u> <u>XS</u> <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED <u>Dr. Santur</u>
NAME: <u>Hicks, Charles</u> D.O.B. <u>11/2/61</u> <u>246241</u> ALLERGIES: <u>None</u> Use Third Date <u>5/19/06</u>	DIAGNOSIS (If Chg'd) <u>SCASA 325mg po qd x 180 days</u> ✓ <u>Glucotrol 10mg po qd x 180 days</u> ✓ <u>Lisinopril 5mg po qd x 180 days</u> <u>AFC BID x 30 days AAA Thin Layer</u> ✓ <u>Aid oint AAA BID x 30 days</u> ✓ <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED <u>Dr. Santur</u>
NAME: <u>Hicks, Charles</u> D.O.B. <u>11/2/61</u> <u>246241</u> ALLERGIES: <u>None</u> Use Second Date <u>5/19/06</u>	DIAGNOSIS (If Chg'd) <u>B/S V/S 2x day x 300</u> ✓ <u>Obtain records from Cooper Green RE</u> <u>Cardiac &amp; DM</u> <u>Lisinopril 27.5/25 mg po qd x 180 days</u> <u>mevacor 20mg po qd x 180 days</u> ✓ <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED <u>Dr. Santur</u>
NAME: <u>Hicks, Charles</u> D.O.B. <u>11/2/61</u> <u>246241</u> ALLERGIES: <u>None</u> Use First Date <u>5/19/06</u>	DIAGNOSIS <u>Cmpz Cho, HgbA1c, TSH, (exams) 140225</u> ✓ <u>EKG, C/P</u> ✓ <u>Eye Clinic Referral</u> ✓ <u>2200 calorie diabetic diet &amp; snack</u> ✓ <u>B/P V 2x wk x 4 wks</u> ✓ <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED <u>Dr. Santur</u>



## PROGRESS NOTES

Date/Time	Inmate's Name: Hicks Charlie Bm246241 D.O.B.: 11/12/61
11/7/06 825B	20 N/A. Eval see 11/6/06 sick call wt 280 T- 98° P- 70 R- 20 22 sat 98% B/P 162/102 JAN
11/7/06	<p>pt. Venous doppler ⊕ for DVT. <u>Plan</u></p> <ol style="list-style-type: none"> <li>① Elevated the legs frequently</li> <li>② Continue using support stockings.</li> <li>③ Cont. to No prolonged standing periods.</li> </ol> <p>AD, B. pt. is diabetic discussed Diabetic diet.</p> <p>RL RL</p>

Date/Time	Inmate's Name:	D.O.B.:
	Hicks, Charles	24624
		11/2/61
10:25-00	Return from FWA Venous Doppler	
3:00pm	on leg. - T 97.8, O2 sat 99%, P 66, R 20	
	B/P 156/88 — S. Taylor MD	
	Patient Back from FWA appt re: venous Doppler	
	Study of leg. & complaints voiced	
	Pt want attorney contacted re: his leg. Instructed	
	pt have attorney suppress records for his review,	
	Will bring back to WCN in 10 days for venous	
	report results. Pt w/o return paperwork	
11:30	Dx/KP re: f/u test result wt 253 T 97.8 P 64	
9:40	R-20 O2 sat 99% 146/88 — JH	
	PT informed results of Doppler study - No	
	evidence of DVT Q & A DONE	
	C/O PAIN Along lateral leg.	
	Severe chronic swelling. Hx DM HTN.	
	PT informed to inspect leg twice daily.	
	CANE & support Stocking given today.	
	Resume ASA qd.	
	EXAM	
	Large leg: 2 severe chronic venous insuff	
	skin hyperpig & dry - No evidence	
	of infection. Fungal nails	
	A: DM II	
	HTN	
	chronic venous insuff.	
	P: exam leg Profiles given cane	
	skin care education. A & D initiated	
	Flu HCN 2-3 wks in carbide	

JH/ML



## PROGRESS NOTES

Date/Time	Inmate's Name: Nicks Charles 246241	D.O.B.: 11/2/61
7-5-06	wt 252 T 98° P 64 R 20 B/P 140/90 O2 SAT 97%	
7/12/06	Chronic Care 20 N/A. nail clipping WT 258 T-98° P-72 B-20 O2 sat 98% B/P 164/96 — <i>Am</i>	
	① C/o fever lasting hours of tensiles. ② Upper tracheal tracheitis & cory.	
9-22-06 825D	20 N/A. Eval c/o neck pain, ✓ B/P et B/S WT 271 BS-167 T-98° P-72 B-20 O2 sat 97% B/P 128/88	
	S: Pt. here for flu sick call. C/o "knot on @ side of neck" x 6 days. Pain @ side turn of neck. Approx 6 days ago c/o chills, fever x 2 days & result of "knot & tenderness" on @ side of neck. Denies cough, nasal drainage, ear pain / drainage, SOB.	
	O: VSS Afebrile. GEN: AAOX3, in NAD. HEENT: Head normocephalic, atraumatic. Eyes: PERLA, EOMs intact. Ears: TMs intact, & drainage. Nose: Mucous patent, & drainage. Neck: @ lymph node enlargement / tenderness 1cm x 1cm @ posterior cervical. Movable. @ warmth. @ JVD. @ carotid bruit. Throat: Pharynx pink. @ PND. Lungs: CTAB. Card: rrrr @ M/G/L/R. Abd: Benign, soft, NT @ BSx4. @ ABM. Ext: @ D/P/R/T pulses. @ generalized. @ LE edema. Presently wearing TED hose.	
	A: 1) Posterior cervical enlarged lymph node a) Possible lymphangitis vs. folliculitis	
	P: 1) DP II 2) Bactrim DS tpo BID x 10 days 3) 1 wk. F/V	





# PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Charles Hicks Date of Request: 11-16-06  
ID # 246241 Date of Birth: 11-2-61 Location: 3 #12

Nature of problem or request: I need to talk to Dr. Corbier because my leg is really hurting me real bad. The fluid in my leg looks like it has gone up my leg and I don't like it at all.

Charles Hicks  
Signature

DO NOT WRITE BELOW THIS LINE

Date: 11/16/06  
Time: 11:17 AM AM PM  
Allergies: SC

7640 SC  
11-17-06  
12:29 PM

RECEIVED	
Date:	
Time:	
Receiving Nurse Initials	

(S)ubjective:

(O)bjective (V/S): T: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ BP: \_\_\_\_\_ WT: \_\_\_\_\_

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
CIRCLE ONE  
Check One: ROUTINE ( ) EMERGENCY ( )  
If Emergency was PHS supervisor notified: Yes ( ) No ( )  
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



## Nursing Evaluation Tool:

## General Sick Call

Facility: Alabama Department of Corrections	
Patient Name: <u>Hicks, Charles</u>	
Inmate Number: <u>246247</u>	Date of Birth: <u>11/12/61</u> <small>First Last MM DD YYYY</small>
Date of Report: <u>11/17/06</u> <small>MM DD YYYY</small>	Time Seen: <u>1230</u> AM/PM <small>Circle One</small>

Subjective: Chief Complaint(s): need to go back to Dr. Carpio and need diabetic shoe. need something for pain, leg hurts on  
Onset: \_\_\_\_\_  
Brief History: have pain and swelling in left leg for a long time.  
(Continue on back if necessary)

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 97.6 P: 84 RR: 20 B/P: 140/92

Examination Findings: Swelling noted left leg. Requesting to see Dr. Carpio to discuss outside appt. and need something for pain.  
(Continue on back if necessary)

☐ Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s): \_\_\_\_\_

☐ Referral NOT REQUIRED

☒ Referral REQUIRED due to the following: (Check all that apply)

☒ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other: \_\_\_\_\_

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☒ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: \_\_\_\_\_

OTC Medications given (Describe) ☐ NO ☐ YES (If Yes List): \_\_\_\_\_

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): \_\_\_\_\_

Date for referral: 1/1/ MM DD YYYY  
Time: \_\_\_\_\_

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): MD review

x

Nurses Signature

Name: T. Saindle

Printed



# PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Charles Hicks Date of Request: 11-7-06  
 ID # 246241 Date of Birth: 11-2-61 Location: 3D-B #12  
 Nature of problem or request: I need to go to another free world  
Doctor to have A test on my Left Leg again. This  
is to Doctor Corbier.

Charles Hicks  
Signature

DO NOT WRITE BELOW THIS LINE

Date:   /  /    
 Time:    AM PM  
 Allergies:   

<p>RECEIVED</p> <p>Date: <u>11/7/06</u></p> <p>Time: <u>8:50</u></p> <p>Receiving Nurse Initials <u>My</u></p>
--

*Refused SC  
11-8-06  
11:55 AM*

(S)ubjective:

(O)bjective (V/S): T:    P:    R:    BP:    WT:   

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
 Check One: ROUTINE ( ) CIRCLE ONE EMERGENCY ( )  
 If Emergency was PHS supervisor notified: Yes ( ) No ( )  
 Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT





## Nursing Evaluation Tool:

## General Sick Call

Facility: Alabama Department of Corrections

Patient Name: Hicks, CharlesInmate Number: 246291Date of Birth: 11/2/61Date of Report: 11/6/06Time Seen: 12 N AM / PM Circle One

Subjective: Chief Complaint(s):

Need to start BS again and leg hurts  
real bad. Request to see 7U doctor @ UAB @ Jackson  
 Onset:

Brief History:

(Continue on back if necessary)

Chronic leg pain and edema. Requesting  
7UHA. Also want blood sugar checks.

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 97.6 P: 80 RR: 20 B/P: 120/78

Examination Findings:

(Continue on back if necessary)

Left leg edematous, c/o real bad pain  
and wants 7UHA.

☐ Check Here if additional notes on back

Assessment: (Referral Status)

Preliminary Determination(s):

☒ Referral NOT REQUIRED

☐ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other:

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☒ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other:

(Describe)

OTC Medications given ☒ NO ☐ YES (If Yes List):Referral: ☒ NO ☐ YES (If Yes, Whom/Where): MD reviewDate for referral: 1/1/Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?):

MM DD YYY

Time

x

J. Swindle

Name:

J. Swindle



# PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Charles Hicks Date of Request: 11-5-06  
 ID # 246241 Date of Birth: 11-2-61 Location: 3Dorm/Bed #12  
 Nature of problem or request: I need to start back checking my blood sugars  
I also need to talk to Dr. Corbier again about seeing a  
free world doctor again, my leg hurts me real real bad.  
I want to go to UAB or Jackson Hospital for test on my leg and  
body please. Charles Hicks

Signature

DO NOT WRITE BELOW THIS LINE

Date:    /   /     
 Time:     AM PM  
 Allergies:    

<p>RECEIVED</p> <p>Date: <u>11/5/06</u></p> <p>Time: <u>8:53pm</u></p> <p>Receiving Nurse Initials <u>JP</u></p>
--

(S)ubjective:

(O)bjective (V/S): T:     P:     R:     BP:     WT:    

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
 CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



# PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Charles Hicks Date of Request: 10-28-06  
 ID # 246241 Date of Birth: 11-02-61 Location: 3 #12  
 Nature of problem or request: I need to see the Doctor because  
my left leg still hurts me. Also, I need a profile  
so I can show it to Sgt. Givens.

Charles Hicks  
Signature

DO NOT WRITE BELOW THIS LINE

Date:    /   /     
 Time:     AM PM  
 Allergies:    

<p>RECEIVED</p> <p>Date: _____</p> <p>Time: _____</p> <p>Receiving Nurse Initials _____</p>
---

(S)ubjective:

*Handwritten notes:*  
 4430-06  
 10.30.06  
 10.30.06

(O)bjective (V/S): T: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ BP: \_\_\_\_\_ WT: \_\_\_\_\_

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
 CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



## Nursing Evaluation Tool:

## General Sick Call

Facility: Alabama Department of Corrections

Patient Name: Hicks, CharlesInmate Number: 246247Date of Birth: 11/2/16/Date of Report: 10/30/06Time Seen: 12<sup>00</sup>

AM / PM Circle One

Subjective: Chief Complaint(s):

Need to see eye doctor, request to see another  
doctor about leg, having a lot of leg pain.

Onset:

Brief History:

(Continue on back if necessary)

Having problem w/ left leg. Pain + swelling

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 97.6 P: 70 RR: 18 B/P: 110/176

Examination Findings:  
 (Continue on back if necessary)

Left

☐ Check Here if additional notes on back

Assessment: (Referral Status)

Preliminary Determination(s):

☒ Referral NOT REQUIRED

☐ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other:

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☐ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other:

(Describe)

OTC Medications given ☐ NO ☐ YES (If Yes List):

Meloxicam 400mg B.i.d x 2 days

Referral: ☒ NO ☐ YES (If Yes, Whom/Where):Date for referral: 1/1/Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?)

Time 12:00

x J. Swindle

Name

Nursing Evaluation Tool:

General Sick Call

Facility: Staton Correctional Facility  
 Patient Name: Nicks, Charles  
 Inmate Number: 246241 Last  
 Date of Birth: 11/2/61 First MM DD YYYY  
 Date of Report: 10/23/06 MM DD YYYY  
 Time Seen: 1155 AM / PM Circle One

Subjective: Chief Complaint(s): Need pink slip to wear slides due to my feet + leg swelling  
 Onset:  
 Brief History: Chronic feet + leg swelling  
 (Continue on back if necessary)

Objective: Vital Signs: (As Indicated) T: 97.6 P: 68 RR: 20 B/P: 110/70  
 Examination Findings: chronic leg swelling left leg  
 (Continue on back if necessary)

Assessment: (Referral Status) Preliminary Determination(s):  
☒ Referral NOT REQUIRED  
☐ Referral REQUIRED due to the following: (Check all that apply)  
☐ Recurrent Complaint (More than 2 visits for the same complaint)  
☐ Other:

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:  
☐ Instructions to return if condition worsens.  
☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)  
☐ Other:

(Describe)  
 OTC Medications given ☐ NO ☐ YES (If Yes List):  
 Referral: ☒ NO ☐ YES (If Yes, Whom/Where): MD review Date for referral: 1/1/ AM DD MY  
 Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?):  
 Time

x J. Swindle LP Name: T. Swindle LP  
 Nurses Signature



**PRISON HEALTH SERVICES, INC.  
SICK CALL REQUEST**

Print Name: Charles Hicks Date of Request: 10/21/06  
ID # 246247 Date of Birth: 11-2-61 Location: 3-#12  
Nature of problem or request: I need the doctor to write me some papers so the people here at Frank Lee would know that I have permission to wear these slides because my left leg is hurting me real bad.  
Charles Hicks  
Signature

**DO NOT WRITE BELOW THIS LINE**

Date:    /   /     
Time:     AM PM  
Allergies:    

RECEIVED
Date: _____
Time: _____
Receiving Nurse Initials _____

**(S)ubjective:**

**(O)bjective** (V/S): T: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ BP: \_\_\_\_\_ WT: \_\_\_\_\_

**(A)ssessment:**

**(P)lan:**

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

**SIGNATURE AND TITLE**

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



**PRISON HEALTH SERVICES, INC.  
SICK CALL REQUEST**

Print Name: Charles Hicks Date of Request: 10/19/06  
 ID # 246241 Date of Birth: 11-2-67 Location: 3-#12  
 Nature of problem or request: I need to have my diabetic  
Blood ~~check~~ sugar checked every morning  
because it is very important.

Charles Hicks  
Signature

**DO NOT WRITE BELOW THIS LINE**

Date:    /   /     
 Time:     AM PM  
 Allergies:    

<p align="center"><b>RECEIVED</b></p> <p>Date: _____</p> <p>Time: _____</p> <p>Receiving Nurse Initials _____</p>
---

*Handwritten:*  
 7/4C SC  
 10-20-06  
 11:45 AM-22

**(S)ubjective:**

**(O)bjective** (V/S): T: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ BP: \_\_\_\_\_ WT: \_\_\_\_\_

**(A)ssessment:**

**(P)lan:**

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
 CIRCLE ONE  
 Check One: ROUTINE ( ) EMERGENCY ( )  
 If Emergency was PHS supervisor notified: Yes ( ) No ( )  
 Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE  
 YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Nursing Evaluation Tool:

General Sick Call

Facility: Station Correctional Facility  
 Patient Name: Hicks, Charles  
 Inmate Number: 246241  
 Date of Report: 10 20 06  
 Date of Birth: 11 12 10  
 Time Seen: 1145 AM PM Circle One

Subjective: Chief Complaint(s): Want B/s done q Am  
 Onset: years ago  
 Brief History: kidney x's some time and want b/s  
 (Continue on back if necessary)

Objective: Vital Signs: (As Indicated) T: 97.6 P: 72 RR: 20 B/P: 140/90  
 Examination Findings: No acute distress, status no problems  
 just want BS qd

Assessment: (Referral Status) Preliminary Determination(s):  
☒ Referral NOT REQUIRED  
☐ Referral REQUIRED due to the following: (Check all that apply)  
☐ Recurrent Complaint (More than 2 visits for the same complaint)  
☐ Other:

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:  
☒ Instructions to return if condition worsens.  
☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)  
☐ Other:

OTC Medications given ☒ NO ☐ YES (If Yes List):

Referral: ☒ NO ☐ YES (If Yes, Whom/Where):

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): MD review  
 Date for referral: 1 1 06

x J. Swindle lpw Name: T. Swindle  
 Nurses Signature Printout





# PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Charles Hicks Date of Request: 10-16-06  
 ID # 246241 Date of Birth: 11-2-61 Location: 3-#12  
 Nature of problem or request: I am requiring about the orthopedic shoes that I suppose it gets Dr. Corbier told me that he will let me know when or where will, I go to the hospital to see about my leg. the reason why my leg really hurts me real bad.  
Charles Hicks  
 Signature

DO NOT WRITE BELOW THIS LINE

Date:   /  /    
 Time:    AM PM  
 Allergies:   

RECEIVED  
 Date:   /  /    
 Time:   :    
 Receiving Nurse Initials   

(S)ubjective:

(O)bjective (V/S): T:    P:    R:    BP:    WT:   

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



# PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Charles Hicks Date of Request: 10-15-06  
ID # 246241 Date of Birth: 11-2-61 Location: 3-12

Nature of problem or request: I am requesting about the orthopedic  
show that I suppose it is to the Corbin told me that  
he will let me know when or were will, I go to the  
hospital to see about my leg, the reason why my leg really  
hurts me real bad. Charles Hicks

Signature

DO NOT WRITE BELOW THIS LINE

Date: 10/15/06  
Time: 2:16 AM PM  
Allergies: \_\_\_\_\_

RECEIVED  
Date: \_\_\_\_\_  
Time: \_\_\_\_\_  
Receiving Nurse Initials \_\_\_\_\_

(S)ubjective:

(O)bjective (V/S): T: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ BP: \_\_\_\_\_ WT: \_\_\_\_\_

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



# PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Charles Hicks Date of Request: 10/10/06  
 ID # 246241 Date of Birth: 11-2-61 Location: 3D and Bed #12  
 Nature of problem or request: I still require about my orthopedics shoes and to get my blood pressure checked. I also need to know how much medicine do I take everyday please. I want to know about every pill and what it is all about.  
Charles Hicks  
 Signature

DO NOT WRITE BELOW THIS LINE

Date:    /   /     
 Time:     AM PM  
 Allergies:    

<p>RECEIVED</p> <p>Date: _____</p> <p>Time: _____</p> <p>Receiving Nurse Initials _____</p>
---

(S)ubjective:

(O)bjective (V/S): T: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ BP: \_\_\_\_\_ WT: \_\_\_\_\_

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



# PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Charles Hicks Date of Request: 10/10/66  
 ID # 246241 Date of Birth: 11-2-61 Location: 3Dorm/Bed #12  
 Nature of problem or request: I still requiring about my orthopedics  
shoes and to get my blood pressure checked. I also  
need to know how much ~~meds~~ medicine I take  
everyday please. I want to know about every pill and what it is all about.  
Charles Hicks  
 Signature

DO NOT WRITE BELOW THIS LINE

Date:   /  /    
 Time:    AM PM  
 Allergies:   

RECEIVED  
 Date:   /  /    
 Time:    AM PM  
 Receiving Nurse Initials   

(S)ubjective: 10-11-66

(O)bjective (V/S): T:    P:    R:    BP:    WT:   

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
 CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



## Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections

Patient Name: Hicks, CharlesInmate Number: 246241 LastDate of Birth: 11 12 1961 MM DD YYYYDate of Report: 10 11 106 MM DD YYYYTime Seen: 1155 AM / PM Circle One

Subjective: Chief Complaint(s): Need B/L checked and want to find out  
 Onset: what B/L checked & for what. want to know

Brief History: Diabetic requesting diabetic shoes, diabetic  
 (Continue on back if necessary) & 4 yrs

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 97.6 P: 80 RR: 20 B/P: 120/86

Examination Findings: Requesting diabetic shoes and wants  
 (Continue on back if necessary) to know about med.

Assessment: (Referral Status)

Preliminary Determination(s):

☐ Check Here if additional notes on back

☒ Referral NOT REQUIRED
☐ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other:

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:
☒ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other:

OTC Medications given ☒ NO ☐ YES (If Yes List):

Referral: ☐ NO ☐ YES (If Yes, Whom/Where): MD Review

Date for referral: 1 1 1 MM DD YYYY

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?)

Time

x J. Swindle LPR Name: T. Swindle LPR



**PRISON HEALTH SERVICES, INC.  
SICK CALL REQUEST**

Print Name: Charles Hicks Date of Request: 9/26/06  
 ID # 246241 Date of Birth: 11-2-61 Location: 2D-Bed #20  
 Nature of problem or request: I need some diabetic orthopedic shoes real bad and also some Elpison salt and a foot tub for my feet because I have swelling in left leg that hurts real bad.  
Charles Hicks  
 Signature

**DO NOT WRITE BELOW THIS LINE**

Date:    /   /     
 Time:     AM PM  
 Allergies:    

<p>RECEIVED          Date: <u>9/26/06</u>          Time: <u>7:50</u>          Receiving Nurse Initials <u>AD</u></p>
--

**(S)ubjective:**

**(O)bjective** (V/S): T:     P:     R:     BP:     WT:    

**(A)ssessment:**

S/C 12:38  
 9-27-06  
 NB

**(P)lan:**

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
 CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



## Nursing Evaluation Tool:

## General Sick Call

Facility: Alabama Department of Corrections

Patient Name:

Hicks

Charles

Inmate Number:

246241

Last

Date of Birth:

First

11 12 161

Mid

MM

DD

YYY

Date of Report:

9 127 06

MM

DD

YYY

Time Seen:

1230

AM (PM) Circle One

Subjective: Chief Complaint(s): request foot socks

Onset: 1982

Brief History:

(Continue on back if necessary)

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 98° P: 72 RR: 14 B/P: 140 / 78

Examination Findings:

(Continue on back if necessary)

 pitting edema to @ foot & @ leg, toenail on feet  
 dark & deformed Diabetic, lungs clear, denies  
 cough

☐ Check Here if additional notes on back

Assessment: (Referral Status)

Preliminary Determination(s):

☒ Referral NOT REQUIRED

☐ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other: Hx appt EMD on 9-29-06

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☒ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other:

(Describe)

OTC Medications given ☐ NO ☐ YES (If Yes List):Referral: ☐ NO ☐ YES (If Yes, Whom/Where):

Date for referral:

MM DD YYY

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?):

Time

x

M Brade 1st

Name:

M Brade 1st





PRISON HEALTH SERVICES, INC.  
SICK CALL REQUEST

Print Name: Charles Hicks Date of Request: 9/20/06  
ID # 246241 Date of Birth: 11-2-61 Location: 2D-B20  
Nature of problem or request: my neck is hurting me on  
my left side real bad. Also, I want to know  
about my ~~di~~ diabetes shoes that i ask about  
before?

Charles Hicks

Signature

DO NOT WRITE BELOW THIS LINE

Date:    /   /     
Time:     AM PM  
Allergies:    

RECEIVED
Date: <u>9/18/06</u>
Time: <u>10:16 pm</u>
Receiving Nurse Initials <u>JR</u>

(S)ubjective:

(O)bjective

(A)ssessment:

(P)lan:

*9/19/06*  
*AB*  
*S/C*  
*1:35 pm*

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

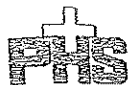
If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



## Nursing Evaluation Tool:

## General Sick Call

Facility: Alabama Department of Corrections

Patient Name: Hicks CharlesInmate Number: 246241Date of Birth: 11 12 161 MM DD YYYYDate of Report: 9 19 106 MM DD YYYYTime Seen: 1:35 AM ☒ PM Circle OneSubjective: Chief Complaint(s): Neck is hurting since Sunday. I noticedOnset: a knot on the lt side of my neck.Brief History: My dad had a knot at the same place and the  
(Continue on back if necessary) Doctors did surgery and took it out at UAB.(Dad's injury.) Since I got the knot I've felt a  
little wooey.☐ Check Here if additional notes on backObjective: Vital Signs: (As Indicated) T: 99.8 P: 96 RR: 12 B/P: 142/82Examination Findings: ON exam, large 1/2 golf ball sized knot palpated  
(Continue on back if necessary) on lt side of neck. Knot Hard. No inflammation, no  
pus observed. Tender to touch.☐ Check Here if additional notes on back

## Assessment: (Referral Status)

## Preliminary Determination(s):

☐ Referral NOT REQUIRED☒ Referral REQUIRED due to the following: (Check all that apply)☐ Recurrent Complaint (More than 2 visits for the same complaint)☒ Other: Knot ON lt side of neckHas knot 9/22/06

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

## Plan: Check All That Apply:

☒ Instructions to return if condition worsens.☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)☐ Other: \_\_\_\_\_

(Describe)

OTC Medications given ☒ NO ☐ YES (If Yes List): \_\_\_\_\_Referral: ☐ NO ☒ YES (If Yes, Whom/Where): MDDate for referral: 1 1 1 MM DD YYYYReferral Type: ☐ Routine ☒ Urgent ☐ Emergent (if emergent who was contacted?) \_\_\_\_\_

Time \_\_\_\_\_

x

Ann Blackman RNName: A. Blackman, RN



PRISON HEALTH SERVICES, INC.  
SICK CALL REQUEST

Print Name: Charles Hicks Date of Request: 9/14/06  
ID # 246241 Date of Birth: 11-2-61 Location: 2#20  
Nature of problem, or request: I need some diabetes shoes  
because it important for me to wear them.

Charles Hicks  
Signature

DO NOT WRITE BELOW THIS LINE

Date:   /  /    
Time:    AM PM  
Allergies:   

RECEIVED
Date: <u>9/14/06</u>
Time: <u>8:30pm</u>
Receiving Nurse Initials <u>hj</u>

(S)ubjective:

(O)bjective

(A)ssessment:

(P)lan:

*g/c*  
*9/15/06*  
*12:05 pm*

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



## Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections

Patient Name: HicksInmate Number: 246241Date of Report: 9 15 06

Last

MM DD YYYY

First

Date of Birth: 11 2 16

MM

DD

YYYY

Time Seen: 12:05

AM/PM

Circle One

**Subjective: Chief Complaint(s):** I Need some Diabetic Shoes. My shoes  
**Onset:** have no support. My feet hurt bad. My  
**Brief History:** Tennis shoes are very flat and have no arches.  
 (Continue on back if necessary) Seems like my ankles are getting larger.

**Objective: Vital Signs: (As Indicated)** T: 98.7 P: 72 RR: 12 B/P: 162/92

**Examination Findings:** Very large BM wears tennis shoes. Ankle swollen  
 (Continue on back if necessary) greatly from poor circulation. Toenail of  
feet extremely thick and dark, deformed. Needs  
po nails cut badly.

**Assessment: (Referral Status)****Preliminary Determination(s):**

□ Check Here if additional notes on back

☐ Referral NOT REQUIRED☒ Referral REQUIRED due to the following: (Check all that apply)☐ Recurrent Complaint (More than 2 visits for the same complaint)☐ Other: MD - Extremely Bad Toenails - Diabetic

**Comment:** You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

**Plan:** Check All That Apply:☐ Instructions to return if condition worsens.☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)☐ Other: \_\_\_\_\_

(Describe)

OTC Medications given ☐ NO ☐ YES (If Yes List): \_\_\_\_\_Referral: ☐ NO ☒ YES (If Yes, Whom/Where): MDReferral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?)Date for referral: 1 1 06

MM

DD

YYYY

Time \_\_\_\_\_

x

Nurses Signature: Ann L. ...Name: A. Blum ...



# PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Charles Hicks Date of Request: 9-11-06  
 ID # 246241 Date of Birth: 11-2-61 Location: 2D / Bed #20  
 Nature of problem or request: I am a high blood and ~~diabetic~~ diabetic  
and I take 95 pain. I take 5 kinds of medicine.  
I suppose to have all of my medicines 150 P  
on me. I just have one of them 150 P.  
Charles Hicks  
 Signature

DO NOT WRITE BELOW THIS LINE

Date:    /   /     
 Time:     AM PM  
 Allergies:    

<p>RECEIVED</p> <p>Date: _____</p> <p>Time: _____</p> <p>Receiving Nurse Initials _____</p>
---

(S)ubjective:

(O)bjective

(A)ssessment:

(P)lan:

*S/C*  
*9/12/06*  
*ABRW*  
*12:25 pm*

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
 Check One: ROUTINE ( ) EMERGENCY ( )  
 If Emergency was PHS supervisor notified: Yes ( ) No ( )  
 Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE  
 YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT  
 GLF1000 7/95



## Nursing Evaluation Tool:

Facility: Alabama Department of Corrections

Patient Name: HicksDate of Birth: 11/2/61Inmate Number: 246241Time Seen: 12:25 ~~AM~~ PM <sup>First</sup> <sub>DD</sub> <sup>MM</sup> <sub>YY</sub>Date of Report: 9/12/069 <sub>MM</sub> 12 <sub>DD</sub> 06 <sub>YY</sub>

Subjective: Chief Complaint(s):

I would like to get All my meds KOP.

Onset:

I'm supposed to get my BP v. I got checked

Brief History:

(Continue on back if necessary)

A few days but feel it needs checking again.I'm getting my Diabetic medicine. The morningNurse has an attitude, she's light skinned.I talked to a male nurse about a mattress pad. My Lt shoulder hurts.

Objective:

Vital Signs: (As Indicated)

T: 98.4P: 72RR: 12BP: 140/90

Examination Findings:

(Continue on back if necessary)

BP as above. Good ROM to Rt arm. No swelling

Assessment: (Referral Status)

☒ Referral NOT REQUIRED☒ Referral REQUIRED due to the following: (Check all that apply)☐ Recurrent Complaint (More than 2 visits for the same complaint)☐ Other:Requests All meds KOPWants BP's

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or the appropriate care to be given.

Plan:

Check All That Apply:

☐ Instructions to return if condition worsens.☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)☐ Other:

(Describe)

OTC Medications given ☐ NO ☐ YES (If Yes List):Referral: ☐ NO ☒ YES (If Yes, Whom/Where): MDReferral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?):X Anna Blakely RN

Nurses Signature

Name:

A. Blakely RN

Printed

Date for referral: 9/12/06



**PRISON HEALTH SERVICES, INC.  
SICK CALL REQUEST**

Print Name: Charles Hicks Date of Request: 8-22-06  
ID # 246241 Date of Birth: 11-2-61 Location: \_\_\_\_\_  
Nature of problem or request: To receive my medicine for  
my diabetes and fluid for my leg and High  
Blood pressure and Aspirin please?

Charles Hicks  
Signature

**DO NOT WRITE BELOW THIS LINE**

Date: \_\_\_/\_\_\_/\_\_\_  
Time: \_\_\_\_\_ AM PM  
Allergies: \_\_\_\_\_

<p align="center"><b>RECEIVED</b></p> <p>Date: _____ Time: _____ Receiving Nurse Initials _____</p>
---

**(S)ubjective:**

**(O)bjective**

**(A)ssessment:**

**(P)lan:**

9/C  
8/23/06  
ABRN  
12:30P

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

**SIGNATURE AND TITLE**

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PHS

## Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections

Patient Name: Hicks CharlesInmate Number: 246241Date of Birth: 11/2/61Date of Report: 8/23/06Time Seen: 12:30AM/PM Circle One

**Subjective:** Chief Complaint(s): Came Back Monday from Court in Jefferson  
 Onset: County. Have not had any medicine since  
 Brief History: Sunday. I get Diabetic medicine, Lasix, ↑ BP  
 (Continue on back if necessary) medicines, Aspirin. I would like my  
medications restarted.

☐ Check Here if additional notes on back

**Objective:** Vital Signs: (As Indicated) T: 98.1 P: 72 RR: 12 B/P: 142/86

Examination Findings: On exam calm, oriented, cooperative.  
 (Continue on back if necessary)

☐ Check Here if additional notes on back

Assessment (Referral Status)

Preliminary Determination(s):

☒ Referral NOT REQUIRED

☒ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other:

*put note on Aug MAR in MAR Book to give meds from KOP Stock until arrival.*

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☒ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other:

(Describe)

OTC Medications given ☐ NO ☐ YES (If Yes List):Referral: ☒ NO ☒ YES (If Yes, Whom/Where): MD/VPDate for referral: 1/1/Referral Type: ☐ Routine ☒ Urgent ☐ Emergent (if emergent who was contacted?):

Time

*Ann Blakely RN*  
 Nurses Signature

Name: A. Blakely

Printed



## Nursing Evaluation Tool:

## General Sick Call

Facility: Alabama Department of Corrections			
Patient Name: <u>Hicks Charles</u>			
Inmate Number: <u>246241</u>	Last	First	MI
Date of Report: <u>1/1/06</u>	MM	DD	YYYY
Date of Birth: <u>11/2/61</u>		Time Seen: <u>AM/PM</u> Circle One	

**Subjective:** Chief Complaint(s): Need to see MD not feeling well at all

Onset: Last week

Brief History: At times I feel very weak ie sundy before last  
 (Continue on back if necessary) I felt very weak as if to pass-out. I had my BSV = 64.  
After eating a sandwich felt better. This occurred several  
times but not as severe.

☐ Check Here if additional notes on back

**Objective:** Vital Signs: (As Indicated) T: 98.2 P: 66 RR: 18 B/P: 148/95

Examination Findings: NOx3. Noted 3am FS ↑ then 3pm FS. average AM FS 7-10  
 (Continue on back if necessary) PM FS = 4-90 (AM ↑ 116 ↓ 84) (PM ↑ 171 ↓ 63). On one occasion  
they had nothing in refing for snack. Pakes glucosted 10mg qd for  
BP med taken daily. BP ↑ 148/95. med taken for BP.  
Linsipil 20mg qd / Moxizide 75/50mg qd / ASA BC 325mg qd.

☐ Check Here if additional notes on back

**Assessment:** (Referral Status)

Preliminary Determination(s):

☒ Referral NOT REQUIRED

☐ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☒ Other: ↑ BP

**Comment:** You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

**Plan:** Check All That Apply:

☒ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other:

(Describe)

OTC Medications given ☐ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): HCU review

Date for referral: 8/3/06

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?)

Time

X

[Signature]  
Nurses Signature

Name:

G. Lyszkawicz  
Printed



**PRISON HEALTH SERVICES, INC.  
SICK CALL REQUEST**

Print Name: Charles Hicks Date of Request: 8/2/06  
ID # 246241 Date of Birth: 11-2-61 Location: 2 Dorm/Bed 20  
Nature of problem or request: I need to see a doctor real  
bad because i am not feeling well at  
all, as soon as possible. I am having trouble  
with my left shoulder, and my diabetes and blood  
Charles Hicks Presu  
Signature

**DO NOT WRITE BELOW THIS LINE**

Date:    /   /     
Time:     AM PM  
Allergies:    

RECEIVED
Date: <u>8/2/06</u>
Time: <u>10:44pm</u>
Receiving Nurse Initials <u>JP</u>

**(S)ubjective:**

**(O)bjective**

**(A)ssessment:**

**(P)lan:**

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

Nursing Evaluation Tool:

General Sick Call

FLYC

Facility: Alabama Department of Corrections

Patient Name: Hick Charles

Inmate Number: 246241 Last

Date of Birth: 11/2/61 First MM DD YYYY

Date of Report: 6/12/06 MM DD YYYY

Time Seen: 3:25 AM/PM CardOne

Subjective: Chief Complaint(s): BBP / missing Mar/meds resolved

Onset: 24 years

Brief History: Had problems & edema in R leg since High school  
(Continue on back if necessary)

Objective: Vital Signs: (As Indicated) T: \_\_\_\_\_ P: \_\_\_\_\_ RR: \_\_\_\_\_ B/P: \_\_\_\_\_ I: \_\_\_\_\_

Examination Findings: 10x3. No diff elevating on 1 bunk due edema & R leg at level 8 (1-10) when weight applied. Occasional pain when walking & pain standing. Status keeps R leg elevated when able. Noted edema R ankle to mid calf about ex signs of D & leg.  
(Continue on back if necessary)

Assessment: (Referral Status)

Preliminary Determination(s):

☐ Referral NOT REQUIRED

☒ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other:

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure the appropriate care to be given.

Plan: Check All That Apply:

☐ Instructions to return if condition worsens.

☒ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow up. ☒ YES ☐ NO (If NO then schedule patient for appropriate follow up visits)

☐ Other:

(Describe)

OTC Medications given ☐ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): HCV review

Date for referral: 6/12/06 MM DD YYYY

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?):

Time

x

[Signature]  
Nurse Signature

Name: G. Lyskanyer  
Printed

Print Name: Charles Hicks Date of Request: 6-10-06  
ID # 246241 Date of Birth: 11-2-61 Location: 4-Docm  
Nature of problem or request: med'ine for my Diabetes, Blood  
pressure And Lassic for my legs, And to check  
my blood pressure And Blood sugar.

RECEIVED  
Date: 6-11-06  
Time: 5pm  
Receiving Nurse Initials: [Signature]

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT





**PRISON HEALTH SERVICES, INC.  
SICK CALL REQUEST**

Print Name: Charles Hicks Date of Request: 6-10-06

ID # 246247 Date of Birth: 11-2-60 Location: C-Deon

Nature of problem or request: Medicine for my Diabetes, High  
Pressure, and LASSIE for my legs, and to check  
my blood pressure and blood sugar.

Charles Hicks  
Signature

**DO NOT WRITE BELOW THIS LINE**

Date:    /   /     
Time:     AM PM  
Allergies:    

<b>RECEIVED</b>	
Date:	<u>6-11-06</u>
Time:	<u>5 pm</u>
Receiving Nurse Initials:	<u>   </u>

**(S)ubjective:**

**(O)bjective** (V/S): T:     P:     R:     BP:     WT:    

**(A)ssessment:**

**(P)lan:**

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT







# DEPARTMENT OF CORRECTIONS

## TRANSFER & RECEIVING SCREENING FORM

<b>RECEIVED: Inmate/Health Record</b> Institution: <u>FLYC</u> Date: <u>6/18/06</u> Time: _____ AM/PM RECEIVED FROM: Institution/Work Release Center/Free-World Hospital <u>KCF</u>	<b>RELEASED: Inmate/Health Record</b> Institution: <u>Kilby</u> Date: <u>6/18/06</u> Time: _____ AM/PM RELEASE FROM: <input type="checkbox"/> Infirmary <input type="checkbox"/> Segregation <input checked="" type="checkbox"/> Population <input type="checkbox"/> Mental Health <input type="checkbox"/> Other _____ RELEASE TO: <input checked="" type="checkbox"/> DOC <input type="checkbox"/> Infirmary <input type="checkbox"/> Mental Health <input type="checkbox"/> _____ Institution/Work Release Center/Free-World Hospital	<b>ALLERGIES:</b> <u>NKA</u> <b>PHYSICAL EXAMINATION</b> Date of last exam: <u>5/19/06</u> Chest X-Ray Date: _____ Result: _____ PPD Reading <u>0 mm</u> Classification: _____ Limitations: _____
<b>RECEIVING MEDICAL STATUS</b> <input checked="" type="checkbox"/> Population <input type="checkbox"/> Infirmary <input type="checkbox"/> Isolation		

## LAB RESULTS -- LAST REPORT

	Date	Normal	Abnormal	YES	NO
CBC	<u>5/20/06</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Urinalysis	<u>5/19/06</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Wears Glasses/Contacts ☒ ☐  
 Dental Prosthesis ☐ ☐  
 Hearing Aide ☐ ☐  
 Other Prosthesis ☐ ☐

Receiving Nurse: [Signature]

## CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS

IDDM HTN

## CURRENT MEDICATION -- DOSAGE AND FREQUENCY

See MAR

MEDICATIONS	<input type="checkbox"/> Sent w / inmate	<input type="checkbox"/> Not sent w / inmate
X-RAY FILM	<input type="checkbox"/> Sent w / inmate	<input type="checkbox"/> Not sent w / inmate
HEALTH RECORD	<input type="checkbox"/> Sent w / inmate	<input type="checkbox"/> Not sent w / inmate
Released to: _____		

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

MEDICATIONS	<input type="checkbox"/> Received	<input checked="" type="checkbox"/> Not Received
X-RAY FILM	<input type="checkbox"/> Received	<input checked="" type="checkbox"/> Not Received
HEALTH RECORD	<input checked="" type="checkbox"/> Received	<input type="checkbox"/> Not Received
CHART REVIEWED	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO

Received by: C. J. Hood

Signature of Receiving Nurse

Date: 6/18/06 Time: 12:10 AM AM/PM

## SCHEDULE FOR CHRONIC CARE CLINIC

DATE: \_\_\_\_\_ LAST CLINIC: \_\_\_\_\_

## FOLLOW-UP CARE NEEDED

	Date	Time	With Whom -- Location (Sending Nurse)	Date/Appt. Made w/Whom (Rec. Nurse)
<input type="checkbox"/> Medical				
<input type="checkbox"/> Dental				
<input type="checkbox"/> Mental Health				

NURSING ASSESSMENT (SENDING NURSE)

	Yes	No
HISTORY		
Drug Use		<input checked="" type="checkbox"/>
Mental Illness		<input checked="" type="checkbox"/>
Suicide Attempt		<input checked="" type="checkbox"/>
Chronic Care	<input checked="" type="checkbox"/>	

	Yes	No
STATUS		
Special Diet		
Appearance		

OTHER PERTINENT NURSING ASSESSMENT

NURSING ASSESSMENT (RECEIVING NURSE)

	Yes	No
SKIN		
Open Sores		<input checked="" type="checkbox"/>
Lice		<input checked="" type="checkbox"/>
Edema		<input checked="" type="checkbox"/>
Warm & Dry		<input checked="" type="checkbox"/>
Cool & Moist		<input checked="" type="checkbox"/>

	Yes	No
CONDITION		
Alert		<input checked="" type="checkbox"/>
Oriented		<input checked="" type="checkbox"/>
Uncooperative		<input type="checkbox"/>
Depressed		<input type="checkbox"/>

## INTAKE

Sick Call Procedures Explained	<input checked="" type="checkbox"/>
Height	<u>6'5"</u>
Weight	<u>255</u>
Blood Pressure	<u>126/88</u>
Temperature	<u>97.8</u>
Pulse Resp.	<u>64/18</u>
Other	

INMATE NAME (LAST, FIRST, MIDDLE)

Hicks, Charles

DOC#

246241

DOB

11/2/61

Race/Sex

B/m

FAC.

KCF

Facility Name: Frank Lee Youth Center		Month/Year of Charting: 10/06	
Aspirin EC 325MG EC Tab 30.00	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	<p>Start Date: 05-22-2006 Prescriber: Lassiter, L.</p> <p>Stop Date: 11-17-2006 RX #: 251540568</p>	
Take 1 tablet(s) by mouth daily	<p>Handwritten: KUP, given 9/16/06, 10/5/06, 30, Charles Hicks, NB, 10/16/06</p>		
Glipizide 10MG Tab 30.00	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	<p>Start Date: 05-22-2006 Prescriber: Lassiter, L.</p> <p>Stop Date: 11-17-2006 RX #: 251540569</p>	
Take 1 tablet(s) by mouth daily	<p>Handwritten: 10/5/06, 30, Charles Hicks, NB, 10/16/06</p>		
Lovastatin 40MG Tab 15.00	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	<p>Start Date: 05-22-2006 Prescriber: Lassiter, L.</p> <p>Stop Date: 11-17-2006 RX #: 251540573</p>	
Take one-half (1/2) tablet(s) by mouth daily	<p>Handwritten: given, 10/16/06, 30, Charles Hicks, NB, 10/16/06</p>		
Hydrochlorothiazide ( for HCTZ ) 25MG Tab 30.00	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	<p>Start Date: 09-15-2006 Prescriber: Corbier, Paul</p> <p>Stop Date: 12-13-2006 RX #: 251941057</p>	
Take 1 tablet(s) by mouth daily	<p>Handwritten: 10/16/06, 30, Charles Hicks, NB, 10/16/06</p>		
Lisinopril 20MG Tab 60.00	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	<p>Start Date: 09-15-2006 Prescriber: Corbier, Paul</p> <p>Stop Date: 12-13-2006 RX #: 251941064</p>	
Take 1 tablet(s) by mouth twice daily	<p>Handwritten: given, 10/16/06, 30, Charles Hicks, NB, 10/16/06</p>		
Lasix 40mg; PO QAM X 2 wks	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	<p>Start Date: 10-2-06 Prescriber: Meet Mahood</p> <p>Stop Date: 10-17-06 RX #:</p>	
	<p>Handwritten: See new order</p>		
Diagnosis	Nurse's Signature	Initial	Documentation Codes
Allergies			
Housing Unit: Population			
Patient ID Number: 246241			
Patient Name: Hicks, Charles			
Date of Birth:			

1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stock
8. Medication Held
9. No Show
10. Other

Facility Name:	Month/Year of Charting:	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
KCL 10mg ÷ PO QAM x 2wks	10/06	CA	X																															
		Start Date:	10-3-06	Prescriber:	Mahood																													
		Stop Date:	10-17-06	RX #:																														
Augmentin 875mg ÷ PO BID x 10 days	10/06	CA	X																															
		Start Date:	10-3-06	Prescriber:	Mahood																													
		Stop Date:	10-13-06	RX #:																														
Motrin 400mg po Bid	10/06	CA																																
		Start Date:	10/10/06	Prescriber:	Corbin																													
		Stop Date:	10/26/06	RX #:																														
Lasix 40mg po Bid	10/06	CA																																
		Start Date:	10/13/06	Prescriber:	Corbin																													
		Stop Date:	10/27/06	RX #:																														
Microlc 10mg 2 po QD	10/06	CA																																
		Start Date:	10/13/06	Prescriber:	Corbin																													
		Stop Date:	10/27/06	RX #:																														
Motrin 400mg Bid per x 2 days	10/06	CA																																
		Start Date:	10-30-06	Prescriber:	P. Dr. Carter																													
		Stop Date:	11-1-06	RX #:																														
Diagnosis	NKA		Nurse's Signature	J. Parker, RN	Initial	JP	Nurse's Signature	Abraham	Initial	AB	Documentation Codes																							
Allergies	NKA		Nurse's Signature	R. B. Brown	Initial	RB	Nurse's Signature		Initial		1. Discontinued Order																							
Housing Unit:	246241		Nurse's Signature	P. B. Brown	Initial	PB	Nurse's Signature		Initial		2. Refused																							
Patient ID Number:	246241		Nurse's Signature		Initial		Nurse's Signature		Initial		3. Patient out of facility																							
Patient Name:	Hicks, Charles		Nurse's Signature		Initial		Nurse's Signature		Initial		4. Charted in Error																							
			Nurse's Signature		Initial		Nurse's Signature		Initial		5. Lock Down																							
			Nurse's Signature		Initial		Nurse's Signature		Initial		6. Self Administered																							
			Nurse's Signature		Initial		Nurse's Signature		Initial		7. Medication out of Stock																							
			Nurse's Signature		Initial		Nurse's Signature		Initial		8. Medication Held																							
			Nurse's Signature		Initial		Nurse's Signature		Initial		9. No Show																							
			Nurse's Signature		Initial		Nurse's Signature		Initial		10. Other																							



Facility Name: Jefferson County Jail		Month/Year of Charting: 05/06																																																
Vasotec 10MG Tab 30.00	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31																		
Take 1 tablet(s) by mouth daily																																																		
		Start Date: 11-12-2005										Prescriber: Banu, Shirin																																						
		Stop Date: 11-11-2006										RX #: 250875681																																						
Glucophage 500MG Tab 30.00	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31																		
Take 1 tablet(s) by mouth every morning																																																		
		Start Date: 11-29-2005										Prescriber: Banu, Shirin																																						
		Stop Date: 05-27-2006										RX #: 250921345																																						
Clonidine HCl 0.3MG Tab 60.00	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31																		
Take 1 tablet(s) by mouth twice daily																																																		
		Start Date: 04-18-2006										Prescriber: Banu, Shirin																																						
		Stop Date: 05-17-2006										RX #: 251413207																																						
Lasix 40MG Tab 30.00	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31																		
Take 1 tablet(s) by mouth daily																																																		
		Start Date: 04-18-2006										Prescriber: Banu, Shirin																																						
		Stop Date: 06-16-2006										RX #: 251413203																																						
Potassium Chloride CR 10MEQ Tab CR 60.00	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31																		
Take 2 tablet(s) by mouth daily																																																		
		Start Date: 04-18-2006										Prescriber: Banu, Shirin																																						
		Stop Date: 05-17-2006										RX #: 251413211																																						
Vasotec 10 mg PO QD x 30 days	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31																		
		Start Date: 5/1/06										Prescriber: Banu/Pharmacia																																						
		Stop Date: 6/1/06										RX #:																																						
Diagnosis	Nurse's Signature										Initial										Nurse's Signature										Initial										Documentation Codes									
Allergies	V. [Signature]										P										J. [Signature]										J										1. Discontinued Order									
Housing Unit: 6A11	C. Thomas										CT																														2. Refused									
Patient ID Number: 199225																																									3. Patient out of facility									
Patient Name: Hicks, Charles																																									4. Charted in Error									
																																									5. Lock Down									
																																									6. Self Administered									
																																									7. Medication out of Stock									
																																									8. Medication Held									
																																									9. No Show									
																																									10. Other									

Facility Name:

Month/Year of Charting:

Vasotec 10mg  
PO BID X 30 days

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
0700																																
2000																																

DC SEE new order  
Renew P 30 days

Start Date: 5/3/06

Prescriber: Banu / Philmore nc

Stop Date: 6/2/06

RX #:

Vasotec 10mg 1 dose  
Now

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
1400																																

Start Date: 5/4/06

Prescriber: Banu

Stop Date:

RX #:

5/4/06 Banu / Thomas

Vasotec 20mg  
Q AM X 30 days

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
0700																															

Renew P 30 days

Start Date: 5/4/06

Prescriber: Banu / Philmore nc

Stop Date: 6/2/06

RX #:

Vasotec 10mg  
PO Q HS X 30 days

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
2000																															

Renew P 30 days

Start Date: 5/4/06

Prescriber: Banu / Philmore nc

Stop Date: 6/2/06

RX #:

Vasotec 10mg  
PO x 1 dose  
Now

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1530																															

Start Date:

Prescriber:

Stop Date:

RX #:

Diagnosis

Nurse's Signature

Initial

Nurse's Signature

Initial

Documentation Codes

Allergies

NKA

Housing Unit: BALI

Patient ID Number: 199 225

Patient Name:

Hicks, Charles

Date of Birth:

11/2/61

1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stock
8. Medication Held
9. No Show
10. Other

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
Allergies	M. Robinson	MR	M. J. Parker	MP	1. Discontinued Order
NKDA					2. Refused
Housing Unit:					3. Patient out of facility
Patient ID Number: 246241					4. Charted in Error
Patient Name:					5. Lock Down
Hicks, Charles					6. Self Administered
					7. Medication out of Stock
					8. Medication Held
					9. No Show
					10. Other
			Date of Birth	11/2/01	



Facility Name: Frank Lee Youth Center		Month/Year of Charting: 09/06	
Maxzide 75-50MG Tab 30.00	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	<p>Start Date: 05-22-2006 Prescriber: Lassiter, L.</p> <p>Stop Date: 11-17-2006 RX #: 251540566</p>	
Take 1 tablet(s) by mouth daily		<p>KOP</p> <p>CG</p> <p>DIC 9/12/06 me</p>	
Aspirin EC 325MG EC Tab 30.00	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	<p>Start Date: 05-22-2006 Prescriber: Lassiter, L.</p> <p>Stop Date: 11-17-2006 RX #: 251540568</p>	
Take 1 tablet(s) by mouth daily		<p>KOP</p> <p>CG</p> <p>Charles Hicks</p> <p>#30 9/16/06</p>	
Glucotrol 10MG Tab 30.00	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	<p>Start Date: 05-22-2006 Prescriber: Lassiter, L.</p> <p>Stop Date: 11-17-2006 RX #: 251540569</p>	
Take 1 tablet(s) by mouth daily		<p>KOP</p> <p>CG</p> <p>Charles Hicks</p> <p>#30 9/16/06</p>	
Mevacor 40MG Tab 15.00	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	<p>Start Date: 05-22-2006 Prescriber: Lassiter, L.</p> <p>Stop Date: 11-17-2006 RX #: 251540573</p>	
Take one-half (1/2) tablet(s) by mouth daily		<p>20mg KOP</p> <p>CG</p> <p>Charles Hicks</p> <p>#30 9/16/06</p>	
Lisinopril 20mg PO QD	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	<p>Start Date: 8/5/06 Prescriber: Howard</p> <p>Stop Date: 2/5/07 RX #:</p>	
		<p>KOP</p> <p>CG</p> <p>Charles Hicks</p> <p>#30 9/16/06</p>	
Bactrim DS i po Bid	Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	<p>Start Date: 9/22/06 Prescriber: Mubead</p> <p>Stop Date: 10/2/06 RX #:</p>	
		<p>BA BP</p> <p>g</p>	
Diagnosis	Nurse's Signature	Initial	Documentation Codes
Allergies: NKA	CG	g	<p>1. Discontinued Order</p> <p>2. Refused</p> <p>3. Patient out of facility</p> <p>4. Charted in Error</p> <p>5. Lock Down</p> <p>6. Self Administered</p> <p>7. Medication out of Stock</p> <p>8. Medication Held</p> <p>9. No Show</p> <p>10. Other</p>
Housing Unit: Population			
Patient ID Number: 246241			
Patient Name: Hicks, Charles			
		Date of Birth: 11/2/61	



## Drug Interaction Report

Generated: 9/6/2006 6:07:44 PM

**To: Corbier, Paul**

**Facility: Frank Lee Youth Center**

**Housing Unit: Population**

**Patient Name: Hicks, Charles**

**ID Number: 246241**

**Drug Name: Lisinopril / 20MG / Tab**

**Severity: Major**

**Interaction: Lisinopril / 20MG / Tab with Maxzide 75-50MG Tab**

Summary: Hyperkalemia, possibly with cardiac arrhythmias or arrest, may occur with the combination of Maxzide and Lisinopril / 20MG / Tab. Serum potassium concentrations should be monitored.

For additional information regarding the potential management of this drug information, please contact the Secure Pharmacy Plus Drug information Center at 1-800-833-2510 x 1724.

*Done*

Facility Name:		Month-Year of Charting																											
Maxzide 75-50MG Tab      30.00 Take 1 tablet(s) by mouth daily		<div style="float:right;">08/06</div>																											
(KOP)	Start Date: 05-22-2006 Stop Date: 11-17-2006	Prescriber: Lassiter, L. RX #: 251540566																											
Aspirin EC 325MG EC Tab      30.00 Take 1 tablet(s) by mouth daily		<div style="float:right;"></div>																											
(KOP)	Start Date: 05-22-2006 Stop Date: 11-17-2006	Prescriber: Lassiter, L. RX #: 251540568																											
Glucotrol 10MG Tab      30.00 Take 1 tablet(s) by mouth daily		<div style="float:right;"></div>																											
(KOP)	Start Date: 05-22-2006 Stop Date: 11-17-2006	Prescriber: Lassiter, L. RX #: 251540569																											
Mevacor 40MG Tab      15.00 Take one-half (1/2) tablet(s) by mouth daily		<div style="float:right;"></div>																											
(KOP)	Start Date: 05-22-2006 Stop Date: 11-17-2006	Prescriber: Lassiter, L. RX #: 251540573																											
Lisinopril 20mg PO qd x 180 days		<div style="float:right;"></div>																											
KH	Start Date: 8/5/06 Stop Date: 2/5/07	Prescriber: Howard camp RX #:																											
		<div style="float:right;"></div>																											
	Start Date: Stop Date:	Give meds from STOCK until KOP Available.																											
Diagnosis		Nurse's Signature																											
Allergies		Initials Documentation Codes																											
Housing Unit:	Population	1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show 10. Other																											
Patient ID Number:	246241																												
Patient Name:	Hicks, Charles	Date of Birth: 11-4-61																											

Facility Name: Frank Lee Youth Center		Month/Year of Charting: 07/06	
Vasotec 5MG Tab 30.00	6A		
Take 1 tablet(s) by mouth daily			
ST		Start Date: 06-01-2006	Prescriber: Robbins, M.
		Stop Date: 11-27-2006	RX #: 251575009
Maxzide 75-50MG Tab 30.00	6A		
Take 1 tablet(s) by mouth daily			
ST		Start Date: 05-22-2006	Prescriber: Lassiter, L.
		Stop Date: 11-17-2006	RX #: 251540566
Aspirin EC 325MG EC Tab 30.00	6A		
Take 1 tablet(s) by mouth daily			
ST		Start Date: 05-22-2006	Prescriber: Lassiter, L.
		Stop Date: 11-17-2006	RX #: 251540568
Glucotrol 10MG Tab 30.00	6A		
Take 1 tablet(s) by mouth daily			
ST		Start Date: 05-22-2006	Prescriber: Lassiter, L.
		Stop Date: 11-17-2006	RX #: 251540569
Mevacor 40MG Tab 15.00	6A		
Take one-half (1/2) tablet(s) by mouth daily			
ST		Start Date: 05-22-2006	Prescriber: Lassiter, L.
		Stop Date: 11-17-2006	RX #: 251540573
Diagnosis		Nurse's Signature	Initial
Allergies NKDA		S. Taylor	ST
Housing Unit: Population		G. Gaudin	G
Patient ID Number: 246241			
Patient Name: Hicks, Charles			
		Date of Birth: 11-2-61	
		Documentation Codes	
		1. Discontinued Order	
		2. Refused	
		3. Patient out of facility	
		4. Charted in Error	
		5. Lock Down	
		6. Self Administered	
		7. Medication out of Stock	
		8. Medication Held	
		9. No Show	
		10. Other	

Facility Name:		KCF	Month/Year of Charting: 6/02																															
Vasotec 5 mg po QD X180 days  (Enalapril)			Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			Start Date: 5/31/02												Prescriber: Dr. Pabon																			
			Stop Date: 11/30/02												RX #:																			
			Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			Start Date:												Prescriber:																			
			Stop Date:												RX #:																			
			Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			Start Date:												Prescriber:																			
			Stop Date:												RX #:																			
			Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			Start Date:												Prescriber:																			
			Stop Date:												RX #:																			
			Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			Start Date:												Prescriber:																			
			Stop Date:												RX #:																			
			Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			Start Date:												Prescriber:																			
			Stop Date:												RX #:																			
			Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			Start Date:												Prescriber:																			
			Stop Date:												RX #:																			
			Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			Start Date:												Prescriber:																			
			Stop Date:												RX #:																			
			Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			Start Date:												Prescriber:																			
			Stop Date:												RX #:																			
			Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			Start Date:												Prescriber:																			
			Stop Date:												RX #:																			
			Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			Start Date:												Prescriber:																			
			Stop Date:												RX #:																			
			Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			Start Date:												Prescriber:																			
			Stop Date:												RX #:																			
			Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			Start Date:												Prescriber:																			
			Stop Date:												RX #:																			
			Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27				

1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stock
8. Medication Hold
9. No Show



## PRISON HEALTH SERVICES: AUTHORIZATION LETTER

<b>Patient Name:</b>	Hicks, Charles	<b>Inmate Number:</b>	246241HI
<b>Service Authorized:</b>	X-Ray: Doppler Study - Standard Cost	<b>Effective Dates:</b>	10/18/2006
<b>Effective:</b>	Visits authorized for 60 days from effective date.	<b>Visits Authorized:</b>	1
<b>Responsible Facility:</b>	Staton Correctional Facility	<b>Contact Name:</b>	Michelle Pope
<b>Authorization Number:</b>	16609600	<b>Telephone Number:</b>	(334)395-5973 Ext 14

**Note to Provider of Services:**

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

**For Payment Please Submit Claims To:**

Prison Health Services  
P.O. Box 967  
Brentwood, TN 37024-0967

**The consulting physician should complete this section.  
The completed form will be sealed in the attached envelope and  
returned with an officer to the correctional facility.**

**Clinical Summary or Attached Report**

**\*\*\* For security and safety, please do not inform patient of possible follow-up appointments. \*\*\***

Signature of Consulting Physician:

Date

Time

Reviewed and Signed By  
Medical Director:

Date

Time



**PRISON HEALTH SERVICES: AUTHORIZATION LETTER**

<b>Patient Name:</b>	Hicks, Charles	<b>Inmate Number:</b>	246241HI
<b>Service Authorized:</b>	Office Visits: Op General Specialty Referral	<b>Effective Dates:</b>	10/13/2006
<b>Effective:</b>	Visits authorized for 60 days from effective date.	<b>Visits Authorized:</b>	1
<b>Responsible Facility:</b>	Staton Correctional Facility	<b>Contact Name:</b>	Michelle Pope
<b>Authorization Number:</b>	16589490	<b>Telephone Number:</b>	(334)395-5973 Ext 14

**Note to Provider of Services:**

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
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**Clinical Summary or Attached Report**

**\*\*\* For security and safety, please do not inform patient of possible follow-up appointments. \*\*\***

Signature of Consulting Physician:

Date

Time

Reviewed and Signed By  
Medical Director:

Date

Time

Please send this for

(must be complete and legible. You must type on  
ee Authorization Letter to the service provider at

of the Appointment

PHS

## DEMOGRAPHICS

Site Name &amp; Number:

Staton 843

Site Phone #

(334) 567-1548

Site Fax #

(334) 567-1538

Patient Name: (Last, First,)

Micks, Charles

Date: (mm/dd/yy)

10.12.06

Alias: (Last, First)

Date of Birth: (mm/dd/yy)

11.02.61

Inmate #

246 241

PHS Custody Date: (mm/dd/yy)

4.13.06

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

SS Number

420-96-0383

Potential Release Date: (mm/dd/yy)

11.20.08

Responsible party:

☒ PHS☐ Auto Ins.☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans)☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

## CLINICAL DATA

Requesting Provider:

☐ Physician☐ NP, PA☐ Dental

Facility Medical Director Signature and Date:

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV)☐ X-ray (XR)☐ Scheduled Admission (SA)☐ Outpatient Surgery (OS)☐ Dialysis (DA)☒ Routine☐ Urgent

Estimated Date of Service (mm/dd/yy)

10/12/06

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy☐ Chemotherapy

Number of Visits/Treatments:

☐ Other:

Specialist referred to:

Harshbarger Orthotics

Type of Consultation, Treatment, Procedure or Surgery:

Request for Diabetic Shoes

Diagnosis: DM @ Diabetes

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

44 x 0 07 = H/O Diabetes  
type II in 2003. Pt. has  
had chronic foot problems  
2nd marked swelling of lower  
extremities.

Results of a complaint directed physical examination:

Legs  
- Swelling @ leg (chronic)  
- evidence of venous stasis  
- PP pulses fairly intact  
- Loss of protective sensation  
per monofilament testing

Previous treatment and response (including medications):

- Venous doppler ordered → results pending  
- Lymphedema A/O  
- Diuretics & diuretics  
A1C - 7.6 (last one)  
- on hypoglycemic meds

\*\*\*For security and safety, please do not inform patient of possible follow-up appointments\*\*\*

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized☐ Alternative Treatment Plan (explain here):☐ More Information Requested: (See Attached)☐ Resubmitted with requested information.

Date resubmitted:

Regional Medical Director Signature,  
printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

CPT code:

UR Auth #:

E. Ellis, RN, DOW

10-13-06

CEXV

FAXED 1M 10/13/06

Please send this for

must be Complete and Legible. You must type c  
ie Authorization Letter to the service provider at

of the Appointment

PHS

## DEMOGRAPHICS

Site Name &amp; Number:

Staton 843

Site Phone #

(334) 567-1548

Site Fax #

(334) 567-1538

Patient Name: (Last, First)

Hicks, Charles

Alias: (Last, First)

Inmate #

246241

SS Number

420-90-0383

Date: (mm/dd/yy)

10.13.06

Date of Birth: (mm/dd/yy)

11.02.06

PHS Custody Date: (mm/dd/yy)

4.13.06

Potential Release Date: (mm/dd/yy)

11.20.08

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

Responsible party:

☒ PHS☐ Auto Ins.☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans)☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

## CLINICAL DATA

Requesting Provider:

☒ Physician☐ NP, PA☐ Dental

Facility Medical Director Signature and Date:

Paul Corbin, MD 10/13/06

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV)☒ X-ray (XR)☐ Scheduled Admission (SA)☐ Outpatient Surgery (OS)☐ Dialysis (DA)☒ Routine☐ Urgent

Estimated Date of Service (mm/dd/yy)

10/13/06

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy☐ Chemotherapy

Number of Visits/Treatments:

☐ Other:

Specialist referred to:

FMI

Type of Consultation, Treatment, Procedure or Surgery:

Venous doppler @ leg

Diagnosis:

ICD-9 code:

② Leg Swelling Pain NO DVT

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

Pt. has type 2 DM, HTN  
 Chronic swelling @ leg  
 some faint pain  
 While symptoms started several years ago  
 he has had swelling in last few months

Results of a complaint directed physical examination:

② leg: 3+ Edema  
 picture of Elephantiasis.  
 Homan's sign equivocal.  
 Dorsalis Pedis pulse 2+.

Previous treatment and response (including medications):

Diuretic therapy  
 Support stockings.

\*\*\*For security and safety, please do not inform patient of possible follow-up appointments\*\*\*

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized☐ Alternative Treatment Plan (explain here):☐ More Information Requested: (See Attached)☐ Resubmitted with requested information.

Date resubmitted:

Regional Medical Director Signature, printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

CPT code:

UR Auth #:

received  
 11/17/06 JMI

Faxed 10/17/06  
 JMI



Date: 10/25/2006  
Patient: Hicks, Charles  
DOB: 11/2/1961  
Physician: P. Corbier, MD  
Tech: Amy Waite, RT  
Chart #: PAT000020360  
Indication: Left leg edema greater than 5 years, painful

SCAN: Bilateral lower extremity Doppler ultrasound.

**TECHNIQUE:** Bilateral lower extremity venous Doppler was performed in the usual manner.

**FINDINGS:**

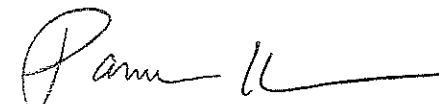
Right extremity: The patient had normal compression, augmentation and flow in the deep venous system of the right extremity.

Left extremity: The patient had calcifications and edema in the region of the left posterior tibial vein. There was normal compression, flow and augmentation of the deep venous system of the left extremity.

**IMPRESSION:**

1. Exam negative for DVT in the right leg.
2. Scattered calcifications and edema surrounding the left posterior tibial vein. No thrombus was identified.

Thank you for this patient referral.



P. Kulback, MD  
PK/bk  
D:10/25/2006  
T:10/26/2006



**Date:** 10/25/2006  
**Patient:** Hicks, Charles  
**DOB:** 11/2/1961  
**Physician:** P. Corbier, MD  
**Tech:** Amy Waite, RT  
**Chart #:** PAT000020360  
**Indication:** Left leg edema greater than 5 years, painful

**SCAN:** Bilateral lower extremity Doppler ultrasound.

**TECHNIQUE:** Bilateral lower extremity venous Doppler was performed in the usual manner.

**FINDINGS:**

**Right extremity:** The patient had normal compression, augmentation and flow in the deep venous system of the right extremity.

**Left extremity:** The patient had calcifications and edema in the region of the left posterior tibial vein. There was normal compression, flow and augmentation of the deep venous system of the left extremity.

**IMPRESSION:**

1. Exam negative for DVT in the right leg.
2. Scattered calcifications and edema surrounding the left posterior tibial vein. No thrombus was identified.

Thank you for this patient referral.

P. Kulback, MD  
 PK/bk  
 D:10/25/2006  
 T:10/26/2006



# UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

FHS

## DEMOGRAPHICS

Site Name & Number:

Staton 843

Site Phone #

(334) 567-1548

Site Fax #

(334) 567-1538

Patient Name: (Last, First)

Hicks, Charles

Alias: (Last, First)

Inmate #

246241

SS Number

420-900383

Date: (mm/dd/yy)

10.03.06

Date of Birth: (mm/dd/yy)

11.02.61

PHS Custody Date: (mm/dd/yy)

4.13.06

Potential Release Date: (mm/dd/yy)

11.20.28

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

Responsible party:

☒ PHS

☐ Auto Ins.

☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans)

☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

## CLINICAL DATA

Requesting Provider:

☐ Physician

☒ NP, PA

☐ Dental

Megan Mahood, CRNP

Facility Medical Director Signature and Date:

Paul Corbier 10/3/06

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office visit (OV)

☒ X-ray (X)

☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS)

☐ Dialysis (DA)

☐ Routine

☐ Urgent

Estimated Date of Service (mm/dd/yy)

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy

☐ Chemotherapy

Number of Visits/Treatments:

☐ Other

Specialist referred to:

IMI

Type of Consultation, Treatment, Procedure or Surgery:

③ Venous doppler of lower extremities

Diagnosis: Peripheral Vascular disease

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

45 y female w/ history of BLE pitting edema progressive since 1982 assoc. dry/scaly skin and c/o intermittent claudication.

PMH: HTN, DM II

Results of a complaint directed physical examination:

↓ DP/PT pulses @ +1/+2 & +2/+3

③ LE pitting edema prog. to

③ patellar region. Dry scaly/hyperkeratotic skin

③ LE & thick ingrown toenails

③ Hoffman's sign

Previous treatment and response (including medications):

① Elevation ③ LE ③ Moxibustion  
③ 40 mg Po QAM

10/25 @ 10 AM

\*\*\*For security and safety, please do not inform patient of possible follow-up appointments\*\*\*

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

☐ Office Service Recommended and Authorized

Date resubmitted:

Regional Medical Director Signature, printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

CPT code:

UR Auth #:

DP

XIL

93965

16573674



# InterQual<sup>®</sup> Smart Sheets<sup>™</sup>

## 2005 - Imaging Criteria Venogram

PATIENT:	Name <u>Charles Hicks</u>	D.O.B. <u>11/2/61</u>	ID# <u>246241</u>	GROUP#
CPT/ICD:	Code	Facility <u>Staton</u>	Service Date	
PROVIDER:	Name <u>Dr. Paul Corbier</u>	ID#	Phone#	
	Signature <u>Paul Corbier</u>	Date		

ICD-9-CM: 88.60, 88.66, 88.67

CPT: 75820, 75822

### INDICATIONS (choose one and see below)

- ☐ 100 Suspected lower extremity DVT  
☐ 200 Suspected upper extremity DVT  
☒ 300 Evaluation of venous patency  
☐ 400 Preoperative evaluation of varicosities  
☐ 500 Mapping of the venous system prior to bypass surgery  
☐ Indication Not Listed (Provide clinical justification below)

#### 100 Suspected lower extremity DVT(BOTH)

- ☐ 110 Sx/findings(TWO)  
     ☐ 111 Pain/tenderness in thigh/calf/ankle  
     ☐ 112 Edema/swelling in thigh/calf/ankle  
     ☐ 113 Homan's sign positive  
     ☐ 114 D-dimer assay positive  
     ☐ 115 High-risk for DVT  
☐ 120 Duplex US(ONE)  
     ☐ 121 Nondiagnostic for lower extremity DVT  
     ☐ 122 Not feasible

#### 200 Suspected upper extremity DVT(BOTH)

- ☐ 210 Sx/findings(TWO)  
     ☐ 211 Pain/tenderness in arm/forearm  
     ☐ 212 Edema/swelling in arm/forearm  
     ☐ 213 D-dimer assay positive  
☐ 220 Duplex US(ONE)  
     ☐ 221 Nondiagnostic for upper extremity DVT  
     ☐ 222 Not feasible

#### 300 Evaluation of venous patency(BOTH)

- ☒ 310 New Sx/findings  
☐ 320 Post vascular reconstruction/angioplasty/thrombolysis

#### 400 Preoperative evaluation of varicosities

\*InterQual<sup>®</sup> criteria are intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient.

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# McKESSON



LabCorp Birmingham  
1801 First Avenue South, Birmingham, AL 35233-0000



Phone: 205-581-3500

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	Page #:
264-205-5298-0	S	MB	COMPLETE	1

#### ADDITIONAL INFORMATION

FLYC		FASTING: Y	
		DOB: 11/02/1961	
PATIENT NAME		SEX	AGE(YR./MOS.)
HICKS,CHARLES		M	44 / 10
PT. ADD.:			
DATE OF COLLECTION TIME		DATE RECEIVED	DATE REPORTED TIME
9/21/2006	7:52	9/21/2006	9/22/2006 8:33
			8042

#### CLINICAL INFORMATION

CD- 41147612641

PHYSICIAN ID.

CORBIER P

PATIENT ID.

246241

ACCOUNT: Staton Correctional Facility

Prison Health Services

PO BOX 56

Elmore

AL 36025-0000

ACCOUNT NUMBER: 01308900

TEST	RESULT	LIMITS	LAB
------	--------	--------	-----

Microalbumin, Random Urine

> Microalbum., U, Random	22.2H ug/mL	0.0 - 17.0	MB
--------------------------	-------------	------------	----

LAB: MB LabCorp Birmingham

DIRECTOR: John Elgin N MD

1801 First Avenue South, Birmingham, AL 35233-0000

*on 28 sample  
9/26/06  
mm*

Pat Name: HICKS, CHARLES	Pat ID: 246241	Spec #: 264-205-5298-0	Seq #: 8042
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Results are Flagged in Accordance with Age Dependent Reference Ranges

Last Page of Report

11/10

Hicks, Charles

KCF

240241

D.O.B.: 11-2-61

\_\_\_\_\_

BSVS  $3A + 3p \times 3d$

[illegible]

\*Check if results called to physician.

[illegible]

Date	Initials	Signatures

ID: #STAT#060525071317

05/25/2006 7:13:16

SINUS RHYTHM

\*\* INTERPRETATION MADE WITHOUT KNOWING PATIENT'S GENDER/AGE \*\*  
WITHIN NORMAL LIMITS

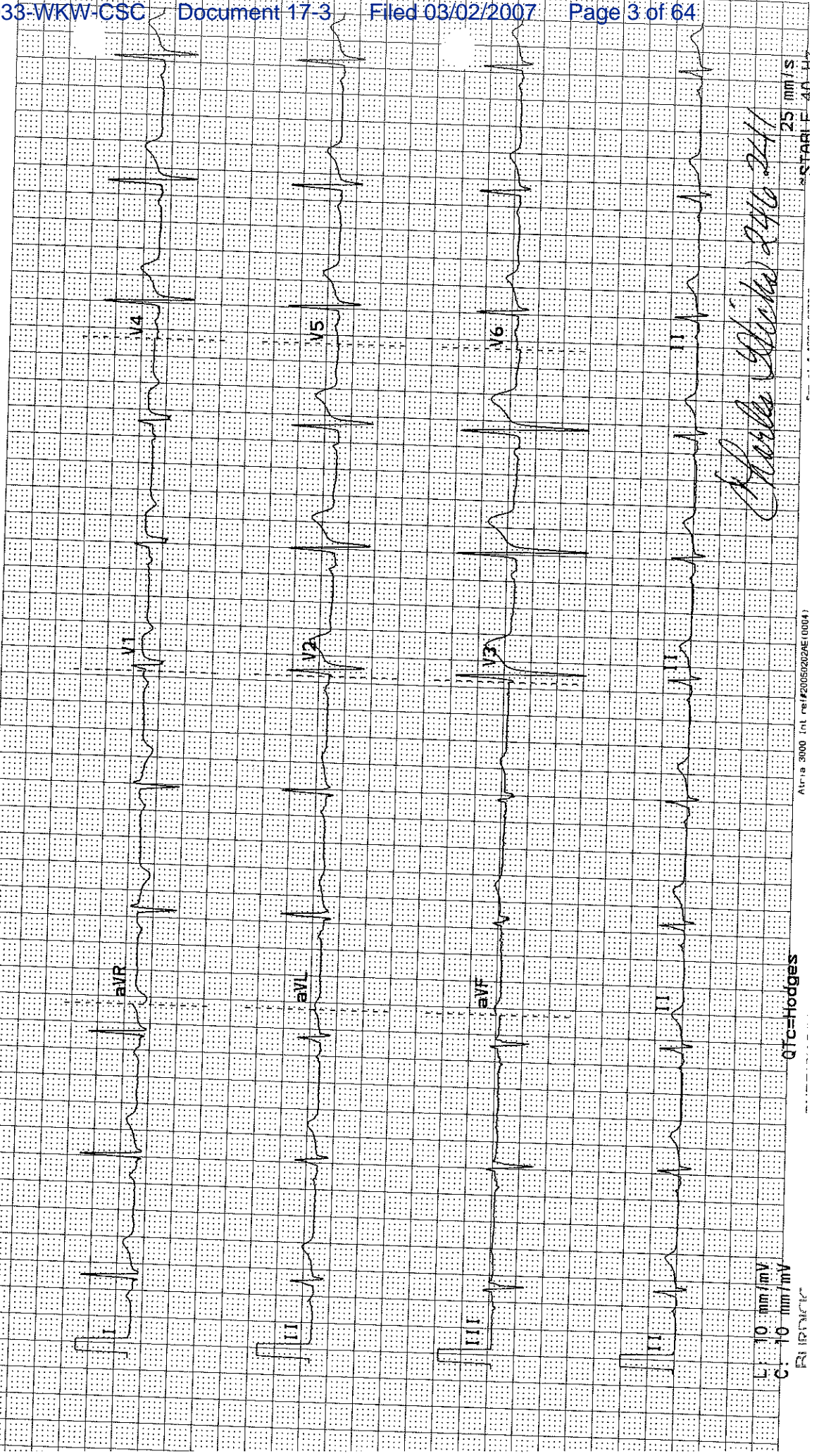
\* Unconfirmed Analysis \*

Summary: NORMAL ECG

P

Vent. Rate:	65 bpm
RR Interval:	914 ms
PR Interval:	156 ms
QRS Duration:	98 ms
QT Interval:	388 ms
QTc Interval:	396 ms
QT Dispersion:	66 ms
P-R-T AXIS:	1° -4° 31°

Charles Hicks 246241  
44  
5/5 246241



QTC=Hodges

RI 10 mm/mV  
CI 10 mm/mV

Atia 3000 Int ref#20050202AE(0004)

25 mm/s  
\*STABLE 4A 4L



LabCorp Birmingham  
1801 First Avenue South, Birmingham, AL 35233-0000

Phone: 205-581-3500

SPECIMEN 142-205-5362-0	TYPE S	PRIMARY LAB MB	REPORT STATUS COMPLETE	Page #: 1
ADDITIONAL INFORMATION				
PE18 5/19		FASTING: N DOB: 11/02/1961		
PATIENT NAME HICKS, CHARLES		SEX M	AGE(YR./MOS.) 44 / 6	
PT. ADD.:				
DATE OF COLLECTION TIME 5/22/2006 11:05	DATE RECEIVED 5/22/2006	DATE REPORTED 5/23/2006	TIME 9:31	957
TEST		RESULT		LAB

CLINICAL INFORMATION CD- 41139331447	
PHYSICIAN ID. ROBBINS M	PATIENT ID. 246241
ACCOUNT: Kilby Correctional Facility Prison Health Services 12201 Wares Ferry Road Mt. Meigs AL 36507-0000	
ACCOUNT NUMBER: 01306900	

CMP14+LP+5AC					
Chemistries					MB
>	Glucose, Serum	132 H	mg/dL	65 - 99	MB
	Uric Acid, Serum	5.4	mg/dL	2.4 - 8.2	MB
	BUN	15	mg/dL	5 - 26	MB
	Creatinine, Serum	1.3	mg/dL	0.5 - 1.5	MB
	BUN/Creatinine Ratio	12		8 - 27	
	Sodium, Serum	138	mmol/L	135 - 148	MB
	Potassium, Serum	4.6	mmol/L	3.5 - 5.5	MB
	Chloride, Serum	101	mmol/L	96 - 109	MB
	Carbon Dioxide, Total	20	mmol/L	20 - 32	MB
	Calcium, Serum	10.1	mg/dL	8.5 - 10.6	MB
>	Phosphorus, Serum	5.0H	mg/dL	2.5 - 4.5	MB
	Protein, Total, Serum	8.0	g/dL	6.0 - 8.5	MB
	Albumin, Serum	4.3	g/dL	3.5 - 5.5	MB
	Globulin, Total	3.7	g/dL	1.5 - 4.5	
	A/G Ratio	1.2		1.1 - 2.5	
	Bilirubin, Total	0.2	mg/dL	0.1 - 1.2	MB
	Alkaline Phosphatase, Serum	88	IU/L	25 - 150	MB
	LDH	194	IU/L	100 - 250	MB
	AST (SGOT)	26	IU/L	0 - 40	MB
	ALT (SGPT)	41	IU/L	0 - 55	MB
>	GGT	75 H	IU/L	0 - 65	MB
	Iron, Serum	57	ug/dL	40 - 155	MB
					MB
Lipids					MB
>	Cholesterol, Total	217 H	mg/dL	100 - 199	MB
>	Triglycerides	156 H	mg/dL	0 - 149	MB
	HDL Cholesterol	42	mg/dL	40 - 59	MB
	VLDL Cholesterol Cal	31	mg/dL	5 - 40	
>	LDL Cholesterol Calc	144 H	mg/dL	0 - 99	
Comment					MB
If initial LDL-cholesterol result is >100 mg/dL, assess for risk factors.					
>	T. Chol/HDL Ratio	5.2H	ratio units	0.0 - 5.0	
	Estimated CHD Risk	1.0	times avg.	0.0 - 1.0	
					T. Chol/HDL Ratio
					Men Women
					1/2 Avg.Risk 3.4 3.3
					Avg.Risk 5.0 4.4

Pat Name: HICKS, CHARLES	Pat ID: 246241	Spec #: 142-205-5362-0	Seq #: 957
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Results are Flagged in Accordance with Age Dependent Reference Ranges

Continued on Next Page





LabCorp Birmingham  
1801 First Avenue South, Birmingham, AL 35233-0000

Phone: 205-581-3500

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	Page #:
142-205-5362-0	S	MB	COMPLETE	2

#### ADDITIONAL INFORMATION

PE18 5/19	FASTING: N DOB: 11/02/1961
PATIENT NAME <b>HICKS, CHARLES</b>	SEX M
PT. ADD.:	AGE(YR./MOS.) 44 / 6

DATE OF COLLECTION	TIME	DATE RECEIVED	DATE REPORTED	TIME	
5/22/2006	11:05	5/22/2006	5/23/2006	9:31	957

#### CLINICAL INFORMATION

CD- 41139331447

PHYSICIAN ID. ROBBINS M  
PATIENT ID. 246241

ACCOUNT: Kilby Correctional Facility  
Prison Health Services  
12201 Wares Ferry Road  
Mt. Meigs AL 36507-0000  
ACCOUNT NUMBER: 01306900

TEST	RESULT	LIMITS	LAB
	2X Avg.Risk	9.6 7.1	
	3X Avg.Risk	23.4 11.0	

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of pre-mature CHD.

Microalb/Creat Ratio, Randm Ur

	Creatinine, Urine	168.8	mg/dL	Not Estab.	MB
>	Microalbum., U, Random	51.3H	ug/mL	0.0 - 17.0	MB
>	Microalb/Creat Ratio	30.4H	ug/mg creat	0.0 - 30.0	
	Hemoglobin Alc				
>	Alc	7.6H	%	4.5 - 5.7	MB

Current guidelines recommend a treatment goal of <7% for diabetic patients. Alc may be overestimated in diabetic patients exhibiting poor control and who are also heterozygous or homozygous for HgbS or HgbC. Total glycohemoglobin is a better indicator of diabetic control in patients with these hemoglobin variants.

TSH 1.353 uIU/mL 0.350 - 5.500 MB

LAB: MB LabCorp Birmingham

DIRECTOR: John Elgin N MD

1801 First Avenue South, Birmingham, AL 35233-0000

Pat Name: HICKS, CHARLES	Pat ID: 246241	Spec #: 142-205-5362-0	Seq #: 957
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Results are Flagged in Accordance with Age Dependent Reference Ranges

Last Page of Report





LabCorp Birmingham

1801 First Avenue South, Birmingham, AL 35233-0000

Phone: 205-581-3500

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	Page #:
142-205-5362-0	S	MB	COMPLETE	1

## ADDITIONAL INFORMATION

PE18

5/19

FASTING: N

DOB: 11/02/1961

## CLINICAL INFORMATION

CD- 41139331447

PATIENT NAME	SEX	AGE(YR./MOS.)
HICKS, CHARLES	M	44 / 6

PT. ADD.:

PHYSICIAN ID.  
ROBBINS MPATIENT ID.  
246241

ACCOUNT: Kilby Correctional Facility  
Prison Health Services  
12201 Wares Ferry Road  
Mt. Meigs AL 36507-0000

DATE OF COLLECTION TIME	DATE RECEIVED	DATE REPORTED	TIME	
5/22/2006 11:05	5/22/2006	5/23/2006	9:31	957

ACCOUNT NUMBER: 01306900

TEST	RESULT	LIMITS	LAB
------	--------	--------	-----

CMP14+LP+5AC

Chemistries

MB

>	Glucose, Serum	132 H	mg/dL	65 - 99	MB
	Uric Acid, Serum	5.4	mg/dL	2.4 - 8.2	MB
	BUN	15	mg/dL	5 - 26	MB
	Creatinine, Serum	1.3	mg/dL	0.5 - 1.5	MB
	BUN/Creatinine Ratio	12		8 - 27	
	Sodium, Serum	138	mmol/L	135 - 148	MB
	Potassium, Serum	4.6	mmol/L	3.5 - 5.5	MB
	Chloride, Serum	101	mmol/L	96 - 109	MB
	Carbon Dioxide, Total	20	mmol/L	20 - 32	MB
	Calcium, Serum	10.1	mg/dL	8.5 - 10.6	MB
>	Phosphorus, Serum	5.0 H	mg/dL	2.5 - 4.5	MB
	Protein, Total, Serum	8.0	g/dL	6.0 - 8.5	MB
	Albumin, Serum	4.3	g/dL	3.5 - 5.5	MB
	Globulin, Total	3.7	g/dL	1.5 - 4.5	
	A/G Ratio	1.2		1.1 - 2.5	
	Bilirubin, Total	0.2	mg/dL	0.1 - 1.2	MB
	Alkaline Phosphatase, Serum	88	IU/L	25 - 150	MB
	LDH	194	IU/L	100 - 250	MB
	AST (SGOT)	26	IU/L	0 - 40	MB
	ALT (SGPT)	41	IU/L	0 - 55	MB
>	GGT	75 H	IU/L	0 - 65	MB
	Iron, Serum	57	ug/dL	40 - 155	MB

Lipids

MB

>	Cholesterol, Total	217 H	mg/dL	100 - 199	MB
>	Triglycerides	156 H	mg/dL	0 - 149	MB
	HDL Cholesterol	42	mg/dL	40 - 59	MB
	VLDL Cholesterol Calc	31	mg/dL	5 - 40	
>	LDL Cholesterol Calc	144 H	mg/dL	0 - 99	

Comment

MB

If initial LDL-cholesterol result is >100 mg/dL, assess for risk factors.

>	T. Chol/HDL Ratio	5.2 H	ratio units	0.0 - 5.0	
	Estimated CHD Risk	1.0	times avg.	0.0 - 1.0	

T. Chol/HDL Ratio

Men Women

1/2 Avg. Risk 3.4 3.3

Avg. Risk 5.0 4.4

Pat Name: HICKS, CHARLES	Pat ID: 246241	Spec #: 142-205-5362-0	Seq #: 957
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Results are Flagged in Accordance with Age Dependent Reference Ranges

Continued on Next Page





LabCorp Birmingham  
1801 First Avenue South, Birmingham, AL 35233-0000

Phone: 205-581-3500

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	Page #:
139-205-5126-0	S	MB	COMPLETE	1

#### ADDITIONAL INFORMATION

NPY18	FASTING: N	
	DOB: 11/02/1961	
PATIENT NAME	SEX	AGE(YR./MOS.)
HICKS, CHARLES	M	44 / 6
PT. ADD.:		

DATE OF COLLECTION TIME	DATE RECEIVED	DATE REPORTED	TIME
5/19/2006 6:00	5/19/2006	5/20/2006 7:16	882

#### CLINICAL INFORMATION

CD- 41139331378

PHYSICIAN ID.	PATIENT ID.
ROBBINS M	246241
ACCOUNT: Kilby Correctional Facility	
Prison Health Services	
12201 Wares Ferry Road	
Mt. Meigs AL 36507-0000	
ACCOUNT NUMBER: 01306900	

TEST	RESULT	LIMITS	LAB
CBC With Differential/Platelet			
White Blood Cell (WBC) Count	5.3 x10E3/uL	4.0 - 10.5	MB
Red Blood Cell (RBC) Count	4.92 x10E6/uL	4.10 - 5.60	MB
Hemoglobin	14.8 g/dL	12.5 - 17.0	MB
Hematocrit	43.3 %	36.0 - 50.0	MB
MCV	88 fL	80 - 98	MB
MCH	30.0 pg	27.0 - 34.0	MB
MCHC	34.1 g/dL	32.0 - 36.0	MB
RDW	14.4 %	11.7 - 15.0	MB
Platelets	323 x10E3/uL	140 - 415	MB
Neutrophils	44 %	40 - 74	MB
Lymphs	39 %	14 - 46	MB
Monocytes	11 %	4 - 13	MB
Eos	5 %	0 - 7	MB
Basos	1 %	0 - 3	MB
Neutrophils (Absolute)	2.3 x10E3/uL	1.8 - 7.8	MB
Lymphs (Absolute)	2.1 x10E3/uL	0.7 - 4.5	MB
Monocytes (Absolute)	0.6 x10E3/uL	0.1 - 1.0	MB
Eos (Absolute)	0.3 x10E3/uL	0.0 - 0.4	MB
Baso (Absolute)	0.1 x10E3/uL	0.0 - 0.2	MB

LAB: MB LabCorp Birmingham

DIRECTOR: John Elgin N MD

1801 First Avenue South, Birmingham, AL 35233-0000

Pat Name: HICKS, CHARLES

Pat ID: 246241

Spec #: 139-205-5126-0

Seq #: 882

Results are Flagged in Accordance with Age Dependent Reference Ranges

Last Page of Report



## DENTAL RECORD TREATMENT

### Services Rendered

[illegible]

PATIENT LAST NAME	FIRST	MIDDLE	DOB	R/S	ID NO.
-------------------	-------	--------	-----	-----	--------



PRISON  
HEALTH  
SERVICES  
INCORPORATED

## DEPARTMENT OF CORRECTIONS

## MENTAL HEALTH SERVICES

## DENTAL RECORD

DENTAL EXAMINATION	RESTORATIONS AND TREATMENTS
Date of Initial Examination <u>5-19-04</u>	Initial Classification _____

Oral Pathology ..... Occlusion ..... Roentgenograms .....	<table style="width: 100%;"> <tr> <td style="width: 30%;">           Gingivitis            Vincent's Infection            Stomatitis            Other Findings         </td> <td style="width: 70%;">           _____            _____            _____            _____         </td> </tr> <tr> <td>           Periapical            Bitewing            Other         </td> <td>           _____            _____            _____         </td> </tr> </table>	Gingivitis Vincent's Infection Stomatitis Other Findings	_____ _____ _____ _____	Periapical Bitewing Other	_____ _____ _____
Gingivitis Vincent's Infection Stomatitis Other Findings	_____ _____ _____ _____				
Periapical Bitewing Other	_____ _____ _____				

## Health Questionnaire

YES	NO		YES	NO	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	V.D.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Allergy (Novocaine, penicillin, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Present Medication	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Anemia or Bleeding Problems
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Asthma	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	High Blood Pressure
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input checked="" type="checkbox"/>	HIV	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Other Disease

SERVICES RENDERED					
Date	Tooth #	DX	TX	Initials	Class
5-19-04	Fm		OKA	g/m	

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
Hicks, Charles	246241	11-2-61	B	KCF

## ALABAMA DEPARTMENT OF CORRECTIONS

## PROBLEM LIST

INMATE NAME Hicks, Charles AIS# 246241Medication Allergies: NKAMedical: Chronic (Long-Term) Problems  
Roman Numerals for Medical/SurgicalMental Health Code: SMI HARM HIST NONE  
Capital Letter for Psychiatric Behavior

Date Identified	Chronic Medical Problem	Mental Health Code	Date Resolved	Provider Initials
5/19/06	HTN			
5/19/06	DM II			
5/20/06	PPd <del>Pharm</del>			
				WW

\*\*If Asthmatic label: Mild - Moderate - or Severe.





KILBY CORRECTIONAL FACILITY  
C A N T E E N   S A L E S   R E C E I P T

HICKS, CHARLES

246241

B/M

6/02/2006

3:35PM

TRANS NR 98845

LI	ITEM NBR	ISSUE QTY	DESCRIPTION	UI	UNIT COST	EXTENDED COST
1	934	1	HONEY BUN	EA	\$.67	\$.67
***** LAST ITEM *****						
TOTAL PURCHASES						\$.67

OLD PMOD BALANCE .70 TOTAL PURCHASE .67 NEW PMOD BALANCE .03  
 TOTAL APPLIED TO WEEKLY LIMIT .00 POSTED BY: INMATE WORKERS

I CERTIFY THAT I RECEIVED ALL ITEMS AND QUANTITIES LISTED ABOVE.

Charles Hicks  
 SIGNATURE

\_\_\_\_\_  
 DATE

BED NBR: M 074B

## PRISON HEALTH SERVICES

Physician's Chronic Care Clinic

Date: 7/5/06

Time:

Facility: FLYC

M. Howard CRNP has h/o Eleph

Check all applicable CIC's being evaluated:

HTN DM

HTN Onset 1992

DM Onset 2003

Card/HTN X DM X GI ID PUL SZ TB

Mother HTN

SUBJECTIVE:

approx. 2 miles QD. Denies tobacco use. Mother h/o DM HTN, Eye exam @ KLBV 05/06. Microalbuminuria last week: Out of control X 2 months.

OBJECTIVE:

BP 140/90 HR 64 RR 20 Temp 98 Wt 252 Peak Flow 02547-9750

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of endorgan complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds, cardiopulmonary, abdomen, extremities; ID-all systems; PUL-HEENT, Cardiopulmonary, AP ratio; SZ-HEENT, neurological; GI-abdomen.

Medx  
MAXIDE 75/30  
EC ASA 325mg  
Glucosol  
Mevacor 20mg QD  
Vasotec (Enalapril) 5mg QD

138	101	15
4.6	20	1.3

EYE EXAM 05/06 @ KLBV  
EXE 5/19/06

NKA

Total Chol. 2174  
TRZ 156  
HDL 42  
VLDL 144  
LDL 144  
Urine CR. 16 8.8  
Microalb 51.3  
HbA1c 7.6  
TSH 1.353  
EKG 05/06 NSE

Fundus - Clear  
Si-Sg - Auscultated PRP  
Chest - symmetrical clear  
AAB  
abd soft & BS present  
Toenail growth - distal  
BPP 3/4 (R/L) + block  
dislocation

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor  
Status: I=Improved, S=Stable, W=Worsened

DM			HTN/CARD			SZ			PUL			ID			GI			OTHER		
Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control		
G	F	P	G	F	P	G	F	P	G	F	P	G	F	P	G	F	P	G	F	P
Status			Status			Status			Status			Status			Status			Status		
I	S	W	I	S	W	I	S	W	I	S	W	I	S	W	I	S	W	I	S	W

PLAN: 1. Activities: ↓ weight by 10.1bs (2lbs weight loss per week)  
2. DIET - Counsel on 2000 cal ADA  
3. Thiazide to 20mg QD + Vasotec  
4. DM - BS 2 X / DAY X 30 days  
5. Check lipid & Microalbuminuria.

F/U: Routine 90 days: Other: 6. Check foot hygiene  
Problem List Updated: Yes No

B. Howard CRNP  
Physician/NP/PA

Hicks Charles  
NAME

M  
GENDER

B  
RACE

246241  
AIS#

11-2-61  
DOB



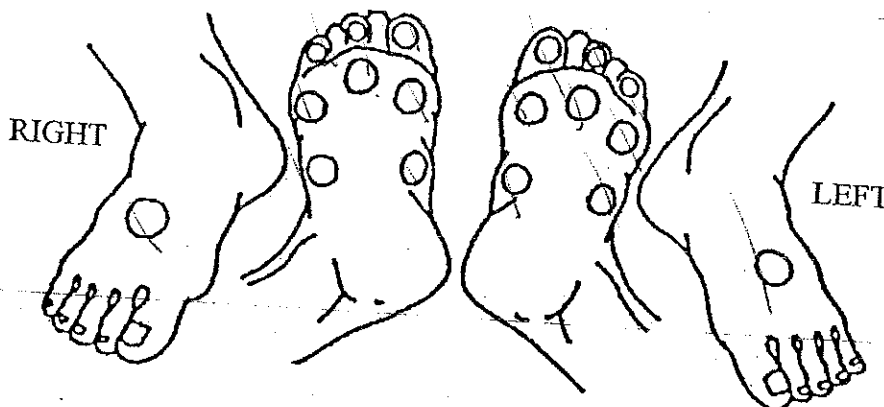
PRISON  
HEALTH  
SERVICES  
INCORPORATED

## MONOFILAMENT TESTING FOR DIABETICS




Fill in the following blanks with a "Y" or "N" to indicate findings

	RIGHT	LEFT
Is there a foot ulcer now?	N	N
Is there a history of foot ulcer?	N	N
Is there an abnormal shape of the foot?	N	N
Is there a toe deformity?	N	N
Are the toenails thick or ingrown?	N	N
Is there callus buildup?	YES	YES
Is there swelling?	NO	NO
Is there elevated skin temperature?	YES (MOLD)	YES
Is there muscle weakness?	N	N
Can the inmate see the bottom of feet?	N	N
Is the inmate wearing improperly fitting shoes?	YES	YES
Does the inmate use footwear appropriate?	NO YES	NO YES BH
Pulses? 3/2 (R/L)	YES	YES
DP/PT	43	42

Note the level of sensation in the circles: (+) → Can feel the 5.07 filament (-) → Can't feel the 5.07 filament



Skin Conditions on the Foot or Between the Toes:

Draw in: Callous , Pre-ulcer , Ulcer  (note length and width in cm)  
Label with: R - Redness, M - Maceration, D - Dryness, T - Tinea

Risk Category:

- ☒ 0 No loss of protective sensation.
- ☐ 1 Loss of protective sensation
- ☐ 2 Loss of protective sensation with either high pressure (callous/deformity), or poor circulation.
- ☐ 3 History of plantar ulceration, neuropathic fracture (Charcot foot) or amputation.

Education done about BH YES Education Received

Name <u>Hicks, Charles</u>	AIS NO <u>246241</u>	Date <u>07/07/06</u>	By <u>B. Howard, CRP</u>
-------------------------------	-------------------------	-------------------------	-----------------------------

PRISON  
HEALTH  
SERVICES  
INCORPORATED

# FINGER STICK BLOOD RECORD FORM

NAME: Hicks, Charles

INSTITUTION/FACILITY: KCF

CELL SITE: \_\_\_\_\_

I.D. # 246241

D.O.B.: 11/2/61

PHYSICIAN ORDER/INSTRUCTIONS: BSVS 3A + 3p X 30d

DATE	TIME	INITIALS	BLOOD SUGAR RESULTS	URINARY KETONE LEVEL (if required)	INITIALS	*	ACTIONS TAKEN/COMMENTS
5/19	15W	UH	105				
5/20	0400	CA	123				
5/20	15W	UH	101				
5/21	0400	CB	128				
5/21	15W	UH	118				
5/22/07	0330	77	102				
5/22	1500	PW	133				
5/23	0330	AB	103				
			113				
5/24/07	0414	UH	107				
5/24	1500	AD	133				
5/25	0400	SS	110				
5/25	1500	AD	93				
5/26	0400	CB	181				
5/26	1500	8	103				
5/27	0400	CA	117				
5/27	1500	8	134				
5/28	0400	CA	118				
5/28	0410	CA	116				
5/29	1510	UH	92				
5/29	0439	UH	105				
5/30	1500	8	117				
5/31	0400	UH	124				

\*Check if results called to physician.

Date	Initials	Signatures

Date	Initials	Signatures

## PRISON HEALTH SERVICES

## Physician's Chronic Care Clinic

Date: 5/24/06

Time: \_\_\_\_\_

Facility: Kilby Correctional FacilityCheck all applicable CIC's being evaluated: Card/HTN DM GI ID PUL SZ TB**SUBJECTIVE:****OBJECTIVE:** BP 140/100 HR 72 RR 16 Temp 98.5 Wt 260 Peak Flow \_\_\_\_\_

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ

Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds, Cardiopulmonary, abdomen, extremities; ID-all systems; PUL-HEENT, Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

- 1) DM
- 2) HTN

no %  
 Labs 5/6 OK. A, C (initial) 7.7  
 mild urine protein. Chol ~ 217  
 lungs clear. Heart MMR i.m.  
 (+) edema (6 leg (chronic, familial), (-) leg.

Maxzide 75/50 mg TP.O. QD  
 KACE 325 mg TP.O. QD  
 Glucotrol 10 mg TP.O. QD  
 Mevacor 20 mg TP.O. QD


**ASSESSMENT:** Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor  
 Status: I=Improved, S=Stable, W=Worsened

DM			HTN/CARD			SZ			PUL			ID			GI			OTHER		
Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control		
G	F	P	G	F	P	G	F	P	G	F	P	G	F	P	G	F	P	G	F	P
Status			Status			Status			Status			Status			Status			Status		
I	S	W	I	S	W	I	S	W	I	S	W	I	S	W	I	S	W	I	S	W

PLAN: 1) add ACE 2) Re-A/C next time  
 2) ↓ wt, ↑ activity 4) Re-lipids ~ 6 mo.

F/U: Routine 90 days: ☒ Other \_\_\_\_\_

Problem List Updated: Yes No



Physician/NP/PA

Hicks, Charles

NAME

male

GENDER



RACE

246241

AIS#

11-2-61

DOB



DEPARTMENT OF CORRECTIONS  
NURSE'S

CV/HTN CHRONIC CARE CLINIC

S: CHRONIC CARE CLINIC

DATE/TIME 5/24/06 @ 0800

O: VS T98 P72 R16 WT 260

BP 140/100

IF BP > 140/90 REFER TO MD/NP/PA

ALLERGIES

None

HX a treadmill? Y (N)

Date:

HX bypass surgery: Y (N)

Date:

Do you smoke?

Use salt?

Family History of CVHTN?

mother & father

Obese?

Stress?

Blurred vision

Headache

Fatigue

Muscle weakness

Polyuria

Epistaxis

S.O.B.

Compliant with meds

KOP

Counseled on risk factors

Describe: Age

Gender - M

Modifiable - smoking, diet, exercise

Labs/EKG WNL

CXR if over 50

Education Done

Topic: Healthy Lifestyle Maintenance

Recently admitted to hospital/infirmary

Notes:

Educational material given

Continue to take leading PPN

Encourage inmate to

take meds as prescribed,

& to exercise regularly

& comply w recommended

diabetic diet

CURRENT MEDICATIONS:

maxzide 75/50 mg 1/2 r. 60

Nevacor 20mg 2. 60

Status: (circle)

IMPROVED UNCHANGED WORSENER

Level of Control: (circle)

GOOD FAIR (POOR)

CCC WITH NURSE (circle)

1, 2, 6 Months

CCC WITH MD (circle)

1, 2, 4, 5, 6 Months

INMATE NAME

NUMBER

AGE

RACE/SEX

SIGNATURE:

Hoke, Charles

246241

44

B/M

Charles Hicks

Control Good---BP < 140/90  
Fair----BP 140-160/90/100  
Poor----BP > 160/100

Status: Improved---BP < previous visit  
Unchanged---BP unchanged  
Worsened---BP increased,



NURSE'S

DIABETIC CHRONIC CARE CLINICS

S: DAY CHRONIC CARE CLINIC				ALLERGIES	
DATE/TIME: 5/31/06 @ 0800				N/A	
O: VS T 98 P 72 R 14					
BP 140/100 WT 240					
Any reactions:				TYPE I <u>TYPE II</u>	
Thirst, vomiting, or abdominal pain		Y	<input checked="" type="radio"/>		
Skin or foot problems:		Y	<input checked="" type="radio"/>		
Foot exam done:		Y	<input checked="" type="radio"/>		
Rotation of injection sites		<u>N/A</u>	N		
Changes in eyes		Y	N		
Dietary compliance:		Y	<input checked="" type="radio"/>		
Noncompliant---Education done		<input checked="" type="radio"/>	N	P: LABS	
Medication compliant		Y	N		
Noncompliant---Education done		<input checked="" type="radio"/>	N		
Tremors		Y	N	Last HgbA1C: Date 5/24/06 Result 7.4%	
Reviewed canteen list		Y	<input checked="" type="radio"/>		
Compliant		<input checked="" type="radio"/>	N		
If noncompliant, education done		<input checked="" type="radio"/>	N		
Infirmary or hospital since last CCC visit		Y	N		
If yes, date		Y	<input checked="" type="radio"/>	ORDERS:	
Review of FLU vaccine		Y	N		
Review of Pneumovax		Y	N		
Fundoscopic exam		Y	N		
Annual Diabetic Checklist updated		Y	N		
NOTES:					
Educational material given					
In 3 mos time A1C					
will be 7.7% + in more					
will be consistent to diet,					
med compliance to exercise					
Education done: 180k & 180k					
Topic: FOOT / skin care					
INMATE NAME		NUMBER	AGE	RACE/SEX	SIGNATURE
Dicks, Charles	246241	44	B1/A	Charles Dicks	

Control: Good---HgbA1C WNL  
Fair---HgbA1C within 2 % of normal  
Poor---HgbA1C > 2% above normal

Status: Improved---Decrease in HgbA1C, and weight decreased by 5%  
Unchanged---No change in HgbA1C and weight  
Worsened---Increase in HgbA1C and weight

CHRONIC CARE CLINIC  
REFERRAL FORM

REFERRAL DATE: 5-19-6  
REFERRING DEPT: P. E.  
NAME OF PATIENT: HICKS, Charles  
AIS# 246241 DOB: 11-2-61 RACE: (B) W  
CLINIC: DM | HTN Quoka

MEDICATIONS: Marzile 75/5g  
ECA 325g  
Glucostrol 10mg  
Mevacor 20g

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATE SEEN IN CLINIC: \_\_\_\_\_

Time: 0930

Facility: Kilby Correctional Facility

Check all applicable CIC's being evaluated: ☒ Card/HTN ☐ DM ☐ GI ☐ ID ☐ PUL ☐ SZ ☐ TB

**SUBJECTIVE:** DX CHAD in 1992, DM I on COA; Ben on monopil, Vasote  
DX DM 2002 on Glucophage

**OBJECTIVE:** BP 170/80 HR 80 RR 20 Temp 98 Wt 155 Peak Flow \_\_\_\_\_  
 NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ  
 Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds,  
 Cardiopulmonary, abdomen, extremities; ID-all systems; PUL-HEENT,  
 Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

Mom & 79 Renal failure  
 DM, HTN

Dad ↓ 85 CHF, HTN

Sib = DM, CAD

Dermis C/P, SOB, OHA/A on visual disturbances  
 + pretibial edema 2+ pitting

S/Sx reg 3/0, 0 Bruits; EBS diminished, wheezing, Rales r  
 Rhonchi; Resp ease

**ASSESSMENT:** Circle the appropriate Degree of Control and Status for each clinic monitored during today's  
 Visit. Degree of Control: G=Good, F=Fair, P=Poor  
 Status: I=Improved, S=Stable, W=Worsened

DM			HTN/CARD			SZ			PUL			ID			GI			OTHER		
Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control		
G	F	P	G	F	P	G	F	P	G	F	P	G	F	P	G	F	P	G	F	P
Status			Status			Status			Status			Status			Status			Status		
I	S	W	I	S	W	I	S	W	I	S	W	I	S	W	I	S	W	I	S	W

**PLAN:** Will place on Maxzide, ASA, bluefrol, V B/P/Pe BS. V lab, ERG, CXR, Eyes  
 Will give BBP 20 edema  
 Diet, footcare, exercise, med compliance stressed

**F/U:** Routine 90 days: \_\_\_\_\_ Other tasks

Non-filament done

Problem List Updated: Yes No

[Signature]  
 Physician/NP/PA

Charles  
 NAME

MALE  
 GENDER

B/W  
 RACE

24624  
 AIS#

11-2-61  
 DOB



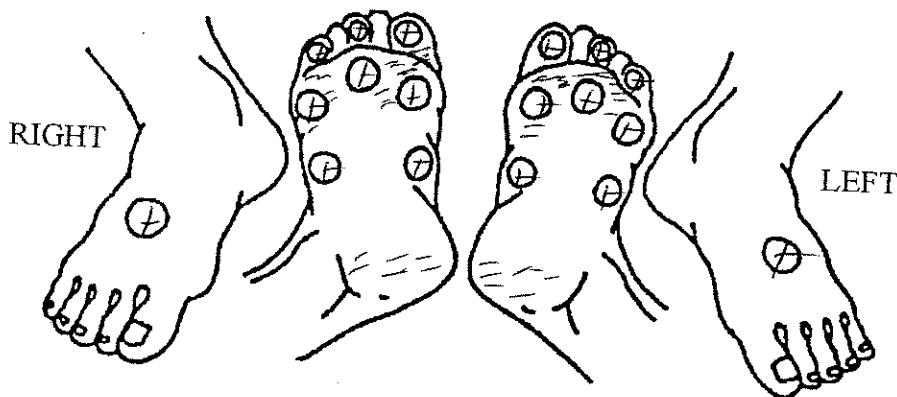
PRISON  
HEALTH  
SERVICES  
INCORPORATED

## MONOFILAMENT TESTING FOR DIABETICS

Fill in the following blanks with a "Y" or "N" to indicate findings




	RIGHT	LEFT
Is there a foot ulcer now?	N	N
Is there a history of foot ulcer?	N	N
Is there an abnormal shape of the foot?	N	N
Is there a toe deformity?	N	N
Are the toenails <u>thick</u> or ingrown?	Y	<del>Y</del>
Is there callus buildup?	Y	Y
Is there swelling?	N	N
Is there elevated skin temperature?	Y 2+	Y 2+
Is there muscle weakness?	N	N
Can the inmate see the bottom of feet?	N	N
Is the inmate wearing improperly fitting shoes?	Y	Y
Does the inmate use footwear appropriate?	Y	Y
Pulses?	Y	Y
DP/PT	2+	2+

Note the level of sensation in the circles: (+) → Can feel the 5.07 filament (-) → Can't feel the 5.07 filament



mycotic nails  
feet peeling  
multiple callous

Skin Conditions on the Foot or Between the Toes:

Draw in: Callous , Pre-ulcer , Ulcer  (note length and width in cm)  
Label with: R - Redness, M - Maceration, D - Dryness, T - Tinea

Risk Category:

- ☐ 0 No loss of protective sensation.  
☐ 1 Loss of protective sensation  
☐ 2 Loss of protective sensation with either high pressure (callous/deformity), or poor circulation.  
☐ 3 History of plantar ulceration, neuropathic fracture (Charcot foot) or amputation.

Education done about foot care Education Received Shantner

Name <u>Hicks, Charles</u>	AMS NO <u>246241</u>	Date <u>11-26</u> <u>5/19/06</u>	By <u>Shantner</u>
-------------------------------	-------------------------	--	-----------------------



PRISON  
HEALTH  
SERVICES  
INCORPORATED

# DIABETIC CHECKLIST

Name Hicks, Charles Number 246241 Period 5/06 to 5/07

Medications: \_\_\_\_\_

Compliance: Yes No

If No, follow-up counseling done: Yes No Date \_\_\_\_\_

Enrolled in Chronic Care: Yes No

Monofilament Foot Exams Done: Yes No

Foot Disorders Treated: Yes No

Educational Material Given: Yes No

Appropriate Diet Ordered: Yes No

Regular Glucose Testing: Yes No

HgbA1C done q 3 months: Yes No

Seen by dental at least annually: Yes No Every 6 months if stable

Urine tested annually for microalbumin: Yes No

Seen by Nurse: \_\_\_\_\_

Seen by MD \_\_\_\_\_

Annual dilated retinal exam \_\_\_\_\_ By \_\_\_\_\_

Referral if necessary \_\_\_\_\_

## Immunization:

Pneumococcus once and repeated after age 64, if more than 5 yrs. Yes No

Influenza annually Yes No

Annual physical exam by MD/NP Yes No Date \_\_\_\_\_

Individual treatment plan Yes No

Updated Yes No

Appropriate Diet Ordered: Yes No

ADOC notified: Yes No



**DIABETIC INTAKE SCREENING  
FOR INTAKES THAT PRESENT WITH DIABETES  
Referral to MD and Seen within 24 hrs of Intake**

NAME Hicks, Charles Number 246241 Date 5/19/06

Diagnosed with diabetes?

Yes No

If yes, then H & P by licensed health care provider with prescriptive authority.

If yes, date H & P completed 5/19/06 by L. Lassiter NP

Random plasma glucose test results 121 Date 5/19/06

If level > 200, then second test within 48 hours

Repeat results

Date

If level < 200, record flagged for a fasting glucose plasma test upon arrival at first assigned institution.

History of fasting Blood Sugar?

Yes

No

Results/Date

History or Frequency of:			
Ketoacidosis	Yes	<u>No</u>	
Hypoglycemia	<u>Yes</u>	No	X 1
Hypoglycemia w/o awareness	Yes	<u>No</u>	
History of known complications	<u>Yes</u>	No	eyes, feet

**Screening Laboratory Evaluation (at reception) All diabetic receive:**

Test	Date	Results in MR	Reviewed
HgbA1c upon arrival			
HDL--Cholesterol *			
Triglycerides *			
Total Cholesterol *			
Urine for microalbumin #140050--24 hr urine			
UA for protein & ketones (onsite)			
Serum Creatinine *			
TSH (when indicated) *			
EKG (onsite)			
Fundoscopy Exam	<u>5-19-06</u>		
Peripheral Pulses			

\* Diagnostic profile II-(048827)-Includes Chem 7, Ca++, LFT's, Lipid Panel, Fe, Phos, Total Protein, Uric acid, Globulin, Transepsidase, Thyroid Panel, CBC w/Diff

Determination of Diabetes ----circle one----Type I Type II

Initial Treatment Plan by MD.....YES NO

Refer to Chronic Care Clinic within 7 days of

Diabetic diet.....YES NO

Education: Documented in medical record.....Date 5/19/06 Informed ADOC .....YES NO

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_



Name: \_\_\_\_\_

c. Current or most recent use: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_d. Current Addictions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

e. Other:

- |   |  |
|---|--|
| _____ 1. In remission 6 months or less          | _____ <del>5</del> 5. Drug use/denies dependency |
| _____ 2. In remission more than one year        | _____ 6. Alcohol use/denies dependency           |
| _____ 3. In remission more than one year        | _____ 7. OBS-drug/alcohol induced                |
| _____ 4. In remission only due to incarceration | _____ 8. Other: _____                            |

**IV. Emotional Status**

- \_\_\_\_\_ a. No significant problems
- \_\_\_\_\_ b. Depressed \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. Anxious or stressful \_\_\_\_\_  
\_\_\_\_\_d. Angry or resentful \_\_\_\_\_  
\_\_\_\_\_e. Confusion or psychotic symptoms \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_f. Mood disturbances \_\_\_\_\_  
\_\_\_\_\_g. Sexual maladjustment \_\_\_\_\_  
\_\_\_\_\_History of sex offenses? ☐ Yes ☒ No List: \_\_\_\_\_h. Paranoid ideation \_\_\_\_\_  
\_\_\_\_\_i. Sleep/appetite disorder \_\_\_\_\_  
\_\_\_\_\_

j. Other

- |                                   |  |                            |
|-----------------------------------|--|----------------------------|
| _____ 1. Symptoms of Hypochondria | _____ 4. Overtly psychotic                 | _____ 7. Behavior disorder |
| _____ 2. Hyperactivity            | _____ 5. Psychosis in remission            | _____ 8. Senile/demented   |
| _____ 3. Violent/uncontrolled     | _____ <del>6</del> 6. Personality disorder | _____ 9. Other             |

Name: \_\_\_\_\_

**V. Mental Deficiency**

\_\_\_\_ Mild (50-70)

\_\_\_\_ Borderline (70-80)

\_\_\_\_ Moderate (35-50)

\_\_\_\_ Organic impairment suspected

\_\_\_\_ Severe (20-35)

\_\_\_\_ Memory Deficit

Remarks: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_**Emotional response to incarceration:** \_\_\_\_\_**VI. Mental Health**\_\_\_\_ a. Outpatient treatment (dates/where) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_\_\_\_\_ b. Inpatient treatment (dates/where) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_\_\_\_\_ c. Psychotropic medication (type/effectiveness) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_\_\_\_\_ d. Family history of mental illness \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_**VII. Management Problems**\_\_\_\_ a. Suicide potential Ideation ☐ Yes ☒ No Plans? ☐ Yes ☒ NoHistory of attempt/gestures \_\_\_\_\_  
 \_\_\_\_\_\_\_\_\_ b. Serious mental illness (specify) \_\_\_\_\_  
 \_\_\_\_\_\_\_\_\_ c. Impulsive/acting out behaviors predicted \_\_\_\_\_  
 \_\_\_\_\_\_\_\_\_ d. Authority Conflict \_\_\_\_\_  
 \_\_\_\_\_\_\_\_\_ e. Manipulative/untrustworthy \_\_\_\_\_  
 \_\_\_\_\_\_\_\_\_ f. Easily victimized \_\_\_\_\_  
 \_\_\_\_\_

Name: \_\_\_\_\_

\_\_\_\_\_ g. Escape potential \_\_\_\_\_

\_\_\_\_\_ h. Assaultiveness \_\_\_\_\_

\_\_\_\_\_ i. Other:

- |                            |   |                                   |
|----------------------------|---|-----------------------------------|
| _____ 1. Malingering       | _____ 4. Physical handicap                                    | _____ 7. Domestic Violence        |
| _____ 2. Mental Deficiency | _____ 5. Self-Mutilation                                      | _____ 8. Gender identity disorder |
| _____ 3. Aged and infirmed | _____ 6. Potential substance abuse in unsupervised situations |                                   |

History of expressive violence? ☐ Yes ☒ No List: \_\_\_\_\_**VIII Educational Needs**

- \_\_\_\_\_ a. ABE/GED \_\_\_\_\_ b. Special Education ☒ c. Trade School \_\_\_\_\_ d. Junior College
- \_\_\_\_\_ e. Life Skills

**IX Mental Health Needs**

- |                                     |                               |                                      |
|-------------------------------------|-------------------------------|--------------------------------------|
| _____ a. Refer to psychiatrist      | _____ e. Sexual adjustment    | _____ i. Self-concept enhancement    |
| _____ b. Substance abuse counseling | _____ f. Reality therapy      | _____ j. Healthy use of leisure time |
| _____ c. Depression                 | _____ g. Anger management     | _____ k. Personal Development        |
| _____ d. Stress management          | _____ h. Values clarification | _____ l. other _____                 |

**Recommendations/Remarks:** (Include accommodations needed for the visual, hearing impaired and other disabilities) 1. Inmate ASP.

Long history of NAMI + similar charges.

Product - TTR.

Darius SAP needs letter Court Ordered.

Court ordered Trade School.

Evaluation Completed by: W. B. ...  
 Psychologist/Psychological Associate

Date: 5/30/06

STATE OF ALABAMA  
DEPARTMENT OF CORRECTIONS  
MENTAL HEALTH SERVICES

RECEPTION MENTAL HEALTH SCREENING EVALUATION

Institution: Killbuck Date/Time Inmate Received: 5/18/06  
Date/Time of Screening: 5/18/06 Signature/Title of Screener: D. McLeod Spn

MENTAL HEALTH TREATMENT PRIOR TO ENTERING THE ADOC:

Yes ☒ No ☐ Psychotropic medication: \_\_\_\_\_  
Yes ☒ No ☐ Medication turned over to ADOC upon arrival? \_\_\_\_\_  
Yes ☒ No ☐ Mental health follow-up in last 90 days: \_\_\_\_\_  
Yes ☒ No ☐ Suicide/self-harm attempts in last 90 days: \_\_\_\_\_

MENTAL HEALTH HISTORY Does inmate report a history of the following (if yes, provide details):

Yes ☒ No ☐ Outpatient treatment: \_\_\_\_\_  
Yes ☒ No ☐ Inpatient treatment: \_\_\_\_\_  
Yes ☒ No ☐ Psychotropic medication: \_\_\_\_\_  
Yes ☒ No ☐ Suicidal attempts: \_\_\_\_\_  
Yes ☒ No ☐ Suicidal thoughts: \_\_\_\_\_  
Yes ☒ No ☐ Head injury: \_\_\_\_\_  
Yes ☒ No ☐ Seizures: \_\_\_\_\_  
Yes ☒ No ☐ Violent behavior: \_\_\_\_\_  
Yes ☒ No ☐ Substance abuse: EtOH  
Yes ☒ No ☐ Substance abuse treatment: \_\_\_\_\_  
Yes ☒ No ☐ Special education classes: \_\_\_\_\_

INMATE SELF-REPORT OF CURRENT STATUS:

Yes ☒ No ☐ First incarceration (reaction): "disappointed"  
Yes ☒ No ☐ Reports family support: Sunt  
Yes ☒ No ☐ Reports significant depression/remorse: \_\_\_\_\_  
Yes ☒ No ☐ Thinking about suicide: \_\_\_\_\_  
Yes ☒ No ☐ Has plan for suicide: \_\_\_\_\_  
Yes ☒ No ☐ Possible to implement suicide plan: \_\_\_\_\_  
Yes ☒ No ☐ Reports hallucinations: \_\_\_\_\_

BEHAVIORAL OBSERVATIONS:

Poor eye contact	Poor hygiene	Unable to pay attention	Unresponsive
Disoriented	Anxious	Unable to follow directions	Unable to read
Crying	Memory deficits	Signs of self-mutilation	Afraid
Illogical speech content	Appears to be hearing voices or seeing things	Paranoid	
Hostile	Other unusual behavior: _____		

DISPOSITION/PLACEMENT RECOMMENDATION (based on reception mental health screening):

Routine housing	Emergency mental health referral
Mental health follow-up but not emergency	Crisis cell placement recommended
Current psychotropic meds verified	Interim supply ordered

Inmate Name: Hicks, Charles AIS #: 246241

Disposition: Inmate Medical Record

Reference: ADOC AR 610, 612, 635  
ADOC Form MH-011 - November 14, 2005

**ALABAMA DEPARTMENT OF CORRECTIONS**  
**INMATE ORIENTATION TO MENTAL HEALTH SERVICES**

The Alabama Department of Corrections provides the following mental health services:

- Assessment and treatment of mental illness
- Referral to a psychiatrist, if necessary for medication
- On-going psychiatric treatment
- Group and individual counseling
- Assistance in dealing with stressful problems (adjustment to prisons, grief and loss, family problems)
- Crisis intervention
- Residential mental health treatment and hospitalization, if necessary

If you wish to speak with mental health staff about routine matters such as scheduling for group or individual counseling, send in a Health Services Request form.

In emergency situations or if you have concerns that need to be addressed immediately, contact any correctional officer so that you may receive mental health assistance as soon as possible.

Your participation in mental health services is voluntary except in emergency situations or when you have been provided due process through administrative review.

If you believe the mental health services provided to you are inadequate, you may file an inmate grievance.

Information about the mental health services provided to you is confidential except in the situations when mental health staff believe that you may be:

- Suicidal
- Homicidal
- Presenting a clear danger of injury to self or others
- Presenting a reasonable clear risk of escape or creation of institutional disorder
- Receiving Psychotropic medication
- Requiring movement to a special unit or cell for observation and treatment
- Requiring transfer to a psychiatric hospital outside of the prison
- Requiring a new program assignment for mental health reasons


Mental health staff has a legal duty to report to appropriate authorities any unreported suspected abuse or neglect of a child.

Mental health and medical staff will have access your mental health records when completing their duties. The following persons may have access to your mental health records on a need to know basis:

- Warden of the institution or designee
- Internal investigation staff and legal counsel working with the ADOC
- Departmental and accrediting audit staff
- Persons authorized by a court order or judgment

All other persons or agencies require an authorization for release of information signed by you before gaining access to your mental health records.

***This information on this form has been explained to me and I have received a copy of the information for my future reference.***



Inmate Signature

246241

AIS #

Date Signed

Hicke, Charles

NMATE:

AIS#:

SITE.

DATE	3am	5am	9am	11am	3pm	5pm
10/25/06					180	
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## Prison Health Services

## REFUSAL OF TREATMENT FORM

Institution: FLYCResident's Name: Charles Hicks ID# \_\_\_\_\_D.O.B. 11-2-61I, Charles Hicks have, this day, knowing that I have a condition  
(Name of Inmate)

requiring medical care as indicated below:

A. Refused medication.

E. Refused X-Ray services.

B. Refused dental care.

F. Refused other diagnostic tests.

C. Refused an outside medical appointment.

G. Refused physical examination.

D. Refused laboratory services.

H. Other (Please specify)

Reason For Refusal No need to be screened

Potential Consequences Explained \_\_\_\_\_

I acknowledge that I have been fully informed of and understand the above treatment recommendations and the risks involved in refusing them. I hereby release and agree to hold harmless the state, statutory authority, all correctional personnel, medical/health personnel from all responsibility and any ill effects which may result from this refusal and I shall personally assume responsibility for my welfare.

I have read this form and certify that I understand its contents.

J. Surinall  
Witness Signature

J. Osborne, COI  
Witness Signature

11-8-06  
Date

Charles Hicks  
Patient Signature

11 55/AM  
Time

NOTE: A refusal by the resident to sign requires the signatures of at least one witness in addition to that of the medical staff member.



## SPECIAL NEEDS COMMUNICATION FORM

Date: 11/3/06

To: FLYC

From: Station Hsu

Inmate Name: Hicks, Charles ID#: 246241

The following action is recommended for medical reasons:

1. House in \_\_\_\_\_
2. Medical Isolation \_\_\_\_\_
3. Work restrictions \_\_\_\_\_
4. May have extra \_\_\_\_\_ until \_\_\_\_\_
5. Other \_\_\_\_\_

**Comments:**

Bottom Bowtie profile X 180 Days Start 11/3/06 Stop 5/3/07

NO Prolonged Standing  
Front of line  
Walking cane  
Anti Embolism Stockings } X 180 days Start 11/3/06 Stop 11/3/06

Date: 11/3/06 MD Signature: Williams Time: \_\_\_\_\_



## DEPARTMENT OF CORRECTIONS

## RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, Hicks, Charles 246241  
(Print Name) (Doc#)

acknowledge receipt of the following medical equipment or appliance:

- ( ) Splint  
( ) Eyeglasses  
( ) Dentures  
( ) Prothesis  
( ) Wheelchair  
☒ Cane  
( ) Crutches  
☒ Other

describe \_\_\_\_\_

describe Antibiotic stocking x 1

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

Charles Hicks 11/3/06  
(Inmate) (Date)

\_\_\_\_\_  
(Witness) (Date)

INMATE NAME (LAST, FIRST, MIDDLE) <u>Hicks, Charles</u>	DOC# <u>246241</u>	DOB <u>11/12/61</u>	R/S	FAC.
--	-----------------------	------------------------	-----	------



# SPECIAL NEEDS COMMUNICATION FORM

Date: 10-27-06

To: DOC

From: Staton HCU

Inmate Name: Hicks, Charles ID#: 246241

The following action is recommended for medical reasons:

1. House in \_\_\_\_\_
2. Medical Isolation \_\_\_\_\_
3. Work restrictions \_\_\_\_\_
4. May have extra \_\_\_\_\_
5. Other \_\_\_\_\_ until \_\_\_\_\_

Comments:

Slide Profile → marked  
peripheral edema X 60 days

Date: 10-28-06 MD Signature: ABlunt / Dr. Corbier Time: 9:00 pm

Treatment Continued:

Epsom Salt Soaks QD x 14 days  
 Bp vs QD x 14 days

Date	Date	Date	Date	Date	Date	Date
10/8	10/9	10/10	10/11	10/12	10/13	10/14
		Done 142/90	Done 142/90		Done	Done 148/90
		MS	MS	Hynes	MS	MS
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Date	Date	Date	Date	Date	Date	Date
10/15	10/16	10/17	10/18	10/19	10/20	10/21
	118/76	120/80	112/85		140/90	
	MS				MS	
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Date	Date	Date	Date	Date	Date	Date
10/22						
150/98						
Tx Done						
MS						

Comments:

Patient Name/Number	Allergies:	Housing Unit:
Hicks, Charles	NKA	FLYC



PRISON  
HEALTH  
SERVICES  
INCORPORATED

## SPECIAL NEEDS COMMUNICATION FORM

Date: 10/24/06

To: Flyc

From: HELL

Inmate Name: Hicks, Charles ID#: 246241

The following action is recommended for medical reasons:

1. House in \_\_\_\_\_
2. Medical Isolation \_\_\_\_\_
3. Work restrictions \_\_\_\_\_
4. May have extra \_\_\_\_\_ until \_\_\_\_\_
5. Other \_\_\_\_\_

Comments:

Blood Sugar checks x 2 weeks to expire 11/4/06

Date: 10/24/06 MD Signature: W. D. Paul / D. McRae Time: 1915



Treatment Continued:

S/p v qd x 14 days

pm

Date	Date	Date	Date	Date	Date	Date
9/13/00	9/14/00	9/15/00	9/16/00	9/17/00	9/18/00	9/19/00
	130/90	116/94	NS	124/88	122/80	150/96
Initials	Byones	LLS	LLS	MB	W	W
	Initials	Initials	Initials	Initials	Initials	Initials

pm

Date	Date	Date	Date	Date	Date	Date
9/20/00	9/21/00	9/22/00	9/23/00	9/24/00	9/25/00	9/26/00
166/96	144/88		122/80		150/99	
LLS	W		W		W	
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Date	Date	Date	Date	Date	Date	Date

Comments:

Patient Name/Number 246241 Hick, Charles	Allergies: NKDA	Housing Unit: FLYC
--	--------------------	-----------------------



# SPECIAL NEEDS COMMUNICATION FORM

Date: 10-20-06

To: F4/C

From: SHCU

Inmate Name: Hicks, Charles ID#: 246241

The following action is recommended for medical reasons:

1. House in \_\_\_\_\_
2. Medical Isolation \_\_\_\_\_
3. Work restrictions \_\_\_\_\_
4. May have extra \_\_\_\_\_ until \_\_\_\_\_
5. Other \_\_\_\_\_

Comments:

2000 CAL ADA diet x 180 days

May purchase diabetic shoes off store

[Signature]

Date: 10/2/06 MD Signature: Mahood, CRNP / J. Parker Time: 10:42pm  
LPN

e-38 of 64  
7/5/06 → 8/5

SITE: FLYC

[illegible]



## MEDICAL INFORMATION TRANSFER FORM

## Confidential Medical Data

To: Jefferson County (Agency) Inmate's Name: Hickson, Charlie  
 (Address) a/k/a: \_\_\_\_\_  
 D.O.B.: 11/2/61 SS #: 420-90-0383  
 From: FHC (Institution) Person Completing Form  
 Name: A. Sawyer, MD  
 Signature: [Signature]  
 (Address) Date: 3/6/06  
 (Telephone) (334) 567-1548

## MEDICAL PROBLEM(S):

HTN  
 DM II

## TREATMENTS/MEDICATIONS:

Maxide 75/50mg P.O. qd  
 Ez ASA 325mg P.O. qd  
 Glucotrol 10mg P.O. qd  
 Mr Vacor 20mg P.O. qd  
 Lisinopril 20mg P.O. qd

## Allergies:

10KVA

## TB Skin Test:

NEG

POS

Date 3/2/06

## CXR:

NEG

POS

Date \_\_\_\_\_

## Pregnant:

Yes

No

Unknown

## Test

RPR: NEG POS

## Treated

Yes No

Date 3/19/06

VDRL: NEG POS

Yes No

GC: NEG POS

Yes No

Other: \_\_\_\_\_ Yes No

## Other Lab Data:



PRISON  
HEALTH  
SERVICES  
INCORPORATED

## SPECIAL NEEDS COMMUNICATION FORM

Date: 7-12-06

To: Frank Lee

From: HCU

Inmate Name: Hicks, Charles ID#: 246241

The following action is recommended for medical reasons:

1. House in \_\_\_\_\_
2. Medical Isolation \_\_\_\_\_
3. Work restrictions \_\_\_\_\_
4. May have extra \_\_\_\_\_ until \_\_\_\_\_
5. Other Start 2000 cal ADA diet x 365 days

Comments:

Date: 7-12-06 MD Signature: Dr. Pleasant / S. Taylor Time: 10:11 AM



## DEPARTMENT OF CORRECTIONS

## RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, Hicks Charles 246241  
(Print Name) (Doc#)

acknowledge receipt of the following medical equipment or appliance:

- ( ) Splint  
( ) Eyeglasses  
( ) Dentures  
( ) Prothesis  
( ) Wheelchair  
( ) Cane  
( ) Crutches  
( ) Other

describe

Thigh Length TED Hose

describe

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

Charles Hicks  
(Inmate)

7-5-06  
(Date)

Al Hall Smith Jr  
(Witness)

7/5/06  
(Date)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
<u>Hicks, Charles</u>	<u>246241</u>	<u>110261</u>	<u>B/m</u>	<u>PLYC</u>



SL

5/28/04

BLOOD PRESSURE RECORD

PHYSICIAN:

[illegible]

Hicks, Charles

LOCATION:

24624/



PRISON  
HEALTH  
SERVICES  
INCORPORATED

# SPECIAL NEEDS COMMUNICATION FORM

Date: 7/5/06

To: FLYC

From: S Hsu

Inmate Name: Hicks, Charles ID#: 246241

The following action is recommended for medical reasons:

1. House in \_\_\_\_\_
2. Medical Isolation \_\_\_\_\_
3. Work restrictions \_\_\_\_\_
4. May have extra \_\_\_\_\_ until \_\_\_\_\_
5. Other \_\_\_\_\_

Comments:

Blood Sugar checks 3A + 3P X 30 Days

Start 7/5/06

Stop 8/5/06

Date: 7/8/06 MD Signature: Howard / Guder Time: \_\_\_\_\_



## SPECIAL NEEDS COMMUNICATION FORM

Date: 5-19-6To: ADOCFrom: phyp.Inmate Name: Hicks, Charles ID#: 246241

The following action is recommended for medical reasons:

1. House in \_\_\_\_\_
2. Medical Isolation \_\_\_\_\_
3. Work restrictions \_\_\_\_\_
4. May have extra Extra Blanket. to allow Inmate to 7 feet X 3 months
5. Other \_\_\_\_\_

## Comments:

Bottom Bunk profile X 3 months  
Trim nails @ TX Time - Notify provider to do.  
AFC Bid X 30 day AAA Thin Layer  
A & D Int. AAA Bid X 30 d.

Date: 5/19/86 MD Signature: Lasater / Rm Time: 10<sup>00</sup> A

*XXF*

Prison Health Services  
Treatment Record

Treatment Ordered:

*Trim nails TX. Time - Call  
Provider to clip nails.*

Date	Date	Date	Date	Date	Date	Date
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Date	Date	Date	Date	Date	Date	Date
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Comments:

Patient Name/Number <i>246241</i> <i>Hicks, Charles</i>	Allergies: <i>NCDA</i>	Housing Unit: <i>E-Down</i> <i>M-7H</i>
---	---------------------------	---

Frank Lee Youth Center

Sick call is performed at 4:00 am (after pill call) in the shift office Monday through Friday. All completed sick call requests and grievances must be given to evening pill call nurse. All sick call requests must be completed and turned by 2:30 pm daily.

Pill call is performed twice a day from the shift office at the times stated below. Pill call is subject to change by health care unit and security.

1. Morning pill call: 3:00 am
2. Noon pill call: None
3. Evening pill call: 4:00 pm

Any dental, medical, or mental health educational information can be obtained through a written request to the Health Services Administrator.

I have had the opportunity to ask questions concerning the above information, and I have received a copy.

Inmate Signature: Charles Hicks

Date: 6-17-06

Nurse Signature: A. Healy

Date: 6/18/06

# IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT) Hicks Charles  
LAST FIRST MI  
DATE OF BIRTH 11-2-61 SS# 420-90-0383

## Housing Recommendations:

General Population X  
Medical Observation Unit \_\_\_\_\_  
Lower Level/Lower Bunk \_\_\_\_\_  
Suicide Precautions \_\_\_\_\_  
Special Watch (15 Minute Checks) \_\_\_\_\_  
Isolation \_\_\_\_\_  
Initiate Universal Precautions \_\_\_\_\_

## Individual found to be:

Frail/Elderly \_\_\_\_\_  
Physically Handicapped \_\_\_\_\_  
Developmentally Disabled \_\_\_\_\_  
Drug/Alcohol Withdrawal \_\_\_\_\_  
Special Mental Health Needs \_\_\_\_\_  
Expressed Suicidal Ideation \_\_\_\_\_  
History of Seizures \_\_\_\_\_  
Other \_\_\_\_\_

CC  
HTN  
XDM II\*

Specify \_\_\_\_\_  
Nurse C. Hill Date 6/18/06





FAX (334) 215-9126  
Phone (334) 215-6678

DEPARTMENT OF CORRECTIONS

AUTHORIZATION FOR RELEASE OF INFORMATION

To: Cooper Green Hosp.  
Birmingham AL.

From: PHS of Kelly Prison  
P.O. Box 11  
Mt. Meigs, AL  
36057

Patient: Hicks, Charles

Inmate ID No.: 246241

Alias: \_\_\_\_\_

Social Security No.: 420 - 90 - 0383

Date of Birth: 11-2-61

Date(s) of Service: 2005 Any

I hereby authorize the above named provider to release to Prison Health Services, Inc. and Kansas Department of Corrections the following confidential information:

- ☒ Physician/Provider's summary of my diagnosis, medications, treatments, prognosis and recent care
- ☒ Admission ☒ Discharge ☒ Operative Summary Reports
- ☒ X-Ray ☐ Special Studies Reports ☐ HIV Test
- ☒ Laboratory Reports ☐ Immunization History ☐ Dental Treatment Records
- ☐ Psychiatric Summary Report ☐ Drug Treatment History & Counseling Reports
- ☒ Other Records Cardiac / DM (Specify information requested)

This authorization shall remain in full force and effect until withdrawn in writing by me. I hereby release and agree to hold provider harmless from any and all liability that may result from such release of information.

Charles Hicks  
(Patient's Signature)

5-19-06  
(Date)

[Signature]  
(Witness' Signature)

5-19-06  
(Date)

The information requested is recognized as confidential and will be used only to ensure prompt and appropriate treatment of the named patient.

Charlene Foster  
(Signature and Title for PHS)

5-19-06  
(Date)



PRISON  
HEALTH  
SERVICES  
INCORPORATED

# SPECIAL NEEDS COMMUNICATION FORM

Date: 5/18/06

To: ADOC

From: WU

Inmate Name: Hicks, Charles ID#: 246241

The following action is recommended for medical reasons:

1. ~~House in~~
2. ~~Medical Isolation~~
3. ~~Work restrictions~~
4. ~~May have extra~~ until
5. ~~Other~~

## Comments:

BS & S Daily 3A + 3P X 30 days.

M

Date: 5/18/06 MD Signature: Protocol/Rokhina Time: 18:00  
med M/W



PRISON  
HEALTH  
SERVICES  
INCORPORATED

# SPECIAL NEEDS COMMUNICATION FORM

Date: 5/19/06

To: \_\_\_\_\_

From: \_\_\_\_\_

Inmate Name: Hicks Charles ID#: 246241

The following action is recommended for medical reasons:

1. House in \_\_\_\_\_
2. ☒ Medical Isolation \_\_\_\_\_
3. Work restrictions \_\_\_\_\_
4. May have extra \_\_\_\_\_ until \_\_\_\_\_
5. ☒ Other \_\_\_\_\_

## Comments:

B/P ✓'s on Monday & Wed  
at 0500 am on westward x  
4wks

Date: 5/19/06 MD Signature: WO. L Lassiter NP/ Time: 9:15

W. Stoughton

## RECEIVING SCREENING FORM

INMATE'S NAME: Hicks, Charles DATE: 5/18/06 TIME: 10<sup>30</sup>  
 DOB: 11-2-61 OFFICER: Col Hives INSTITUTION: KILBY

## RECEIVING OFFICER'S VISUAL OPINION

	YES	NO
Is the inmate conscious?	<u>X</u>	_____
Does the inmate have any obvious pain or bleeding or other symptoms suggesting the need for doctor's care?	_____	<u>  </u>
Are there any visible signs of trauma or illness requiring immediate emergency or doctor's care?	_____	<u>  </u>
Any obvious fever, jaundice, or other evidence of infection which might spread through the institution?	_____	<u>  </u>
Is the skin in poor condition or show signs of vermin or rashes?	_____	<u>  </u>
Does the inmate appear to be under the influence of alcohol, or drugs?	_____	<u>  </u>
Are there any signs of alcohol or drug withdrawal? (Extreme perspiration, shakes, nausea, pinpoint pupils, etc.)	_____	<u>  </u>
Is the inmate making any verbal threats to staff or other inmates?	_____	<u>  </u>
Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?	_____	<u>  </u>
Does the inmate have any obvious physical handicaps?	_____	<u>  </u>

## FOR THE OFFICER

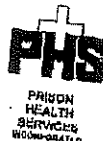
Was the new inmate oriented on sick/dental call procedures?

This inmate was   X   a. Released for normal processing  
 \_\_\_\_\_ b. Referred to health care unit  
 \_\_\_\_\_ c. Immediately sent to the health care unit.

Col Hives  
 Officer's Signature

This form will be completed at receiving and will be filed in the inmate's medical jacket to comply with NCCH Standards.





FAX (334) 215-9126  
Phone (334) 215-6678

## DEPARTMENT OF CORRECTIONS

## AUTHORIZATION FOR RELEASE OF INFORMATION

To: Cooper Green Hosp.  
Birmingham AL

From: PHS of Kelly Prison  
P.O. Box 4  
Mt. Meigs, AL  
36057

Patient: Hicks, Charles

Alias:

Inmate ID No.: 246241

Date of Birth: 11-2-61

Social Security No.: 420-90-0383

Date(s) of Service: 2005 my

I hereby authorize the above named provider to release to Prison Health Services, Inc. and Kansas Department of Corrections the following confidential information:

- ☒ Physician/Provider's summary of my diagnosis, medications, treatments, prognosis and recent care  
☒ Admission ☒ Discharge 336334  
☒ X-Ray ☐ Special Studies Reports ☒ Operative Summary Reports  
☒ Laboratory Reports ☐ Immunization History ☐ HIV Test  
☐ Psychiatric Summary Report ☐ Drug Treatment History & Counseling Reports  
☒ Other Records Cardiac / DM ☐ Dental Treatment Records

(Specify information requested)

This authorization shall remain in full force and effect until withdrawn in writing by me. I hereby release and agree to hold provider harmless from any and all liability that may result from such release of information.

Charles Hicks  
(Patient's Signature)

5-19-06  
(Date)

[Signature]  
(Witness' Signature)

5-19-06  
(Date)

The information requested is recognized as confidential and will be used only to ensure prompt and appropriate treatment of the named patient.

Charlotte Josten  
(Signature and Title for PHS)

5-19-06  
(Date)

PHS-MD-70037



**JEFFERSON HEALTH SYSTEM**  
**COOPER GREEN HOSPITAL**  
**EMERGENCY DEPARTMENT RECORD**  
**EMERGENCY SERVICES CARE PROTOCOLS**

TIME \_\_\_\_\_ DATE \_\_\_\_\_

**CHEST PAIN**

- OLD CHART, CARDIAC MONITOR, SALINE LOCK
- STAT ECG
- CBC, CMP, CHEST PAIN PANEL, MG, PCXR
- PULSE OXIMETRY
- \_\_\_\_\_ O2 per \_\_\_\_\_
- UDS
- UCG IF INDICATED
- ASPIRIN 81MG TO CHEW IF NO ALLERGY
- NITROGLYCERIN 0.4 MG SL Q 5 MIN (IF SBP > 90)
- LABELOLOL 5 MG IV (IF SBP > 90)

**BRAIN ATTACK/  
ALTERED MENTAL STATUS**

- OLD CHART, CARDIAC MONITOR, SALINE LOCK, ECG, ACCUCHECK
- CBC, CMP, PT/PTT, T4, TSH, B12, U/A, PCXR
- PULSE OXIMETRY
- \_\_\_\_\_ O2 per \_\_\_\_\_
- BRAIN CT
- UDS
- UCG IF INDICATED

**SUSPECTED OVERDOSE**

- OLD CHART, CARDIAC MONITOR, SALINE LOCK, ECG, ACCUCHECK
- CBC, CMP, ACETAMINOPHEN & SALICYLATE LEVEL
- ETOH LEVEL IF INDICATED
- PULSE OXIMETRY
- \_\_\_\_\_ O2 per \_\_\_\_\_
- UDS
- UCG IF INDICATED

**SOB/RESPIRATORY DISTRESS**

- OLD CHART, CARDIAC MONITOR, SALINE LOCK
- CBC, CMP, ABG (IF SAT < 90)
- UCG IF INDICATED
- PULSE OXIMETRY (O2 IF SAT < 90)
- \_\_\_\_\_ O2 per \_\_\_\_\_
- ALBUTEROL/ATROVENT NEBS Q 15 MIN X'S 3
- ECG
- SOLUMEDROL 125 MG IV
- BLOOD CULTURES X 2 BEFORE ANTIBIOTICS (IF TEMP > 100.6)
- ROCEPHIN 1 GM IV
- LEVAQUIN 500MG IV

**ETOH INTOXICATION**

- OLD CHART, SALINE LOCK
- CBC, CMP, ETOH, MG, ACCUCHECK
- IV FLUIDS WITH 1 AMP MVL FOLATE, THIAMINE 100MG
- PULSE OXIMETRY (O2 IF SAT < 90)
- \_\_\_\_\_ O2 per \_\_\_\_\_
- UDS IF INDICATED
- UCG IF INDICATED

**GI BLEED**

- OLD CHART, CARDIAC MONITOR
- CBC, CMP, PT/PTT, U/A, PCXR
- TYPE AND SCREEN IF INDICATED
- UCG IF INDICATED
- IV FLUIDS NS @ \_\_\_\_\_ ML/HR
- NG TUBE IF INDICATED
- HEMOCULT STOOLS
- ABDOMINAL SERIES

**NEW ONSET SEIZURE**

- OLD CHART, CARDIAC MONITOR, SALINE LOCK
- CBC, BMP, CA, MG, ACCUCHECK
- UDS IF INDICATED
- ETOH IF INDICATED
- UCG IF INDICATED
- PULSE OXIMETRY (O2 IF SAT < 90)
- \_\_\_\_\_ O2 per \_\_\_\_\_
- BRAIN CT
- ATIVAN 2 MG FOR ACTIVE SEIZURES

**RESPIRATORY PRECAUTIONS**

**SICKLE CELL CRISIS**

- OLD CHART, CARDIAC MONITOR, SALINE LOCK, PCXR
- IV FLUIDS NS @ \_\_\_\_\_ ML/HR
- CBC, RETICULOCYTE COUNT, CMP, UA
- UCG IF INDICATED
- PULSE OXIMETRY (O2 IF SAT < 90)
- \_\_\_\_\_ O2 per \_\_\_\_\_
- DILAUDID 2 MG IV

**FEVER > 100.6 IMMUNOCOMPROMISED/  
AGE 60 OR OLDER**

- OLD CHART, SALINE LOCK, PCXR
- CBC, CMP, UA, URINE C & S
- BLOOD CULTURES X 2 BEFORE ANTIBIOTICS (IF TEMP > 100.6)
- UCG IF INDICATED
- PULSE OXIMETRY (O2 IF SAT < 90)
- \_\_\_\_\_ O2 per \_\_\_\_\_
- ACETAMINOPHEN 650 MG PO OR RECTAL PRN FOR TEMP > 100.6

**SUSPECTED RENAL COLIC**

- OLD CHART, SALINE LOCK
- CBC, CMP, UA
- ABDOMINAL SERIES
- UCG IF INDICATED

**SUSPECTED PYLEONEPHRITIS**

- OLD CHART, SALINE LOCK
- CBC, CMP, UA, URINE, C & S
- UCG IF INDICATED
- ACETAMINOPHEN 650 MG PO OR RECTAL PRN FOR TEMP > 100.6

**LOWER ABD PAIN/  
VAGINAL BLEEDING**

- OLD CHART, SALINE LOCK
- CBC, CMP, UA
- UCG IF INDICATED
- SERUM QUANT. HCG IF UCG POSITIVE
- TYPE & RH IF PREGNANT AND BLEEDING
- ABDOMINAL SERIES
- ACETAMINOPHEN 650 MG PO OR RECTAL PRN FOR TEMP > 100.6

**EXTREMITY INJURY**

- SALINE LOCK
- IMMOBILIZE/ELEVATE EXTREMITY
- APPLY COLD COMPRESS IF INJURY < 48 HRS
- OLD
- TETANUS TOXOID. 0.5 ML IM IF INDICATED
- X-RAY \_\_\_\_\_
- UCG IF INDICATED

**SUSPECTED HIP FRACTURED**

- SALINE LOCK
- CBC, CMP, UA
- X-RAY □ R HIP □ L HIP
- X-RAY \_\_\_\_\_
- UCG IF INDICATED

**LACERATIONS**

- CLEAN WOUND WITH SALINE
- X-RAY IF FOREIGN BODY/FRACTURE SUSPECTED
- X-RAY \_\_\_\_\_
- TETANUS TOXOID. 0.5 ML IM IF INDICATED
- SUTURE SET-UP

**MEDICAL CLEARANCE FOR  
PSYCHIATRIC EVALUATION**

- 3C, BMP
- YOH
- YS
- UCG IF INDICATED

**THERAPEUTIC LEVELS WHEN INDICATED**

- DIGOXIN
- THEOPHYLLINE
- DILANTIN
- PHENOBARBITAL
- PROTIME (PT) / INR

MD SIGNATURE \_\_\_\_\_

RN SIGNATURE \_\_\_\_\_

CLERK'S SIGNATURE \_\_\_\_\_

- Done without MD order
- Requires Physician order

JEREMSON HEALTH SYSTEM  
COOPER GREEN HOSPITAL  
EMERGENCY DEPARTMENT RECORD

Chief complaint: incarcerated for 1 month, out of meds 1 week  
C/o legs swelling more in (L) leg. Denies any SOB or chest pain  
really just needs ✓ up. w/ to get PND to follow

Time seen by physician 12:00

□ Symptom/Location

□ Severity

□ Modifying Factors

□ Context/Mechanism of Injury

□ Quality

□ Duration

□ Timing

□ Associated Signs & Sx

□ EMS Direction

Level 1, 2, 3 Documentation - 1 system, problem pertinent

✓ All systems negative except as noted

Unable to fully assess due to:

( ) altered LOC ( ) patient condition ( ) other

✓ All normal

write negatives

circle positive

Level 4 Documentation - 2 to 8 systems

Pain Severity 0 - 1 - 2 - 3 - 4 - 5 (Circle One)

Level 5 Documentation - 10+ systems

ENT	sore throat	nasobloods	rhinorrhea	dysuria	discharge	dyspareunia	change MS	agitation	suicidal
	hoarse	throat swelling	hearing loss	frequency	irreg menses	flank pain	confusion	depression	hostile
	otalgia	drooling		hematuria	urine output	post UTI	memory loss		
CV	chest pain	rapid ht beat	LE edema	myalgias	neck/back pain	redness	fatigue	polyuria	hair change
	palpitations	slow ht beat	orthopnea	arthralgias	inflammation	heat	weakness	polydipsia	heat tolerance
	PND			limping	previous injury				
RES	SOB	prod. cough	DOE	rash	bruising	contusions	bleeding	nodules	
	pleuritic CP	nonprod. cough		swelling	lacerations	abrasions	bruising	petechiae	
	hemoptysis	croupy cough							
GI	nausea	diarrhea	pain	headache	numbness	change func	rhinorrhea	atopic dermat.	
	vomiting	constipation	bloating	weakness	change LOC	paresthesias	asthma	cneezing	
	melena	jaundice	blood in stool	change speech	developmental delay		itchy eyes		

Level 1, 2, 3 Documentation - None

Level 4 Documentation - One area

Level 5 Documentation - 2 of 3 areas

RISK FACTORS

Age > 35 years

CAD

MTN

DM NIDDM

Family H/O CAD/MI

Menopause

Bilateral Oophorectomy

Cocaine within 1 week

Tobacco use

CA

CVA

Asthma

PVD

CA

CVA

BZ

CC

CC

CC

CC

CC

CC

CC

CC

CC

CC

CC

CC

CC

ALLERGIES & MED'S

✓ See Attached Notes.

NKDA

□ See Attached Notes.

27086674

Level 2, 3 - 2 to 4 body areas / organ systems		All elements not circled/struck/checked/annotated - were not pertinent	
Physical Examination		Level 4 - 6 to 7 body areas / organ systems	
<b>Physical Examination Incomplete due to critical condition of patient.</b> <input checked="" type="checkbox"/> Vital signs per nurses notes <input checked="" type="checkbox"/> Well developed, well nourished <input checked="" type="checkbox"/> No acute pain/distress <input checked="" type="checkbox"/> No Odor ETOH		<input checked="" type="checkbox"/> Normal <input checked="" type="checkbox"/> No adenopathy of neck <input checked="" type="checkbox"/> No adenopathy of axillae <input checked="" type="checkbox"/> No adenopathy of groin <input checked="" type="checkbox"/> No adenopathy, other _____	
<b>C O N S</b> <input checked="" type="checkbox"/> Alert and oriented to TPP <input checked="" type="checkbox"/> No abnormalities of mood or affect <input checked="" type="checkbox"/> Memory (recent and remote) intact <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed <input type="checkbox"/> Suicidal	more below <input type="checkbox"/>	<b>M U S</b> <input type="checkbox"/> Normal gait and station <input type="checkbox"/> Normal digits and nails <input type="checkbox"/> Muscle atrophy <input type="checkbox"/> Neurovascular status intact	more below <input type="checkbox"/>
<b>E Y E S</b> <input checked="" type="checkbox"/> PERRL <input checked="" type="checkbox"/> Conjunctivae and lids normal <input checked="" type="checkbox"/> Fundi and discs normal <input checked="" type="checkbox"/> EOM normal	more below <input type="checkbox"/>	<b>E A R S</b> <input checked="" type="checkbox"/> Otoloscopic exam of external canal and TMJ normal <input checked="" type="checkbox"/> Nasal mucosa, turbinates, and septum normal <input checked="" type="checkbox"/> Mouth, tongue, and pharynx normal <input checked="" type="checkbox"/> Pharynx without edema, exudate, or injection	more below <input type="checkbox"/>
<b>N E C K</b> <input checked="" type="checkbox"/> Neck supple <input checked="" type="checkbox"/> No JVD <input checked="" type="checkbox"/> No thyromegaly <input checked="" type="checkbox"/> No bruits	more below <input type="checkbox"/>	<input type="checkbox"/> No masses or tenderness <input type="checkbox"/> Breasts symmetric <input type="checkbox"/> No discharge	more below <input type="checkbox"/>
<b>R E S P</b> <input checked="" type="checkbox"/> Normal respiratory effort and excursion <input checked="" type="checkbox"/> No rhos, rhonchi or wheezes <input checked="" type="checkbox"/> Normal to percussion <input checked="" type="checkbox"/> Equal air entry	more below <input type="checkbox"/>	<b>G I</b> <input checked="" type="checkbox"/> Normal PMI with no thrills, RSR <input checked="" type="checkbox"/> No murmurs or gallops <input checked="" type="checkbox"/> Normal carotids <input checked="" type="checkbox"/> No edema or varicocele	more below <input type="checkbox"/>
<b>C V</b> <input checked="" type="checkbox"/> Normal speech <input checked="" type="checkbox"/> CN II-XII intact <input checked="" type="checkbox"/> DTRs normal, no pathologic reflexes <input checked="" type="checkbox"/> Normal motor and sensory function <input checked="" type="checkbox"/> No ataxia <input checked="" type="checkbox"/> Normal corneal reflex <input checked="" type="checkbox"/> Normal Romberg	more below <input type="checkbox"/>	<input checked="" type="checkbox"/> No masses, tenderness, rebound or guarding <input checked="" type="checkbox"/> Normal liver, spleen, kidney <input checked="" type="checkbox"/> No hernia <input checked="" type="checkbox"/> Rectal, not indicated <input type="checkbox"/> rectal normal <input type="checkbox"/> homocult negative/positive <input checked="" type="checkbox"/> Normal bowel sounds	more below <input type="checkbox"/>
<b>E N D</b> <input checked="" type="checkbox"/> Genitalia normal to inspection <input checked="" type="checkbox"/> No masses, tenderness or adenopathy <input checked="" type="checkbox"/> Genitalia normal to palpation <input checked="" type="checkbox"/> Normal cervix <input checked="" type="checkbox"/> Normal bimanual <input type="checkbox"/> bladder <input type="checkbox"/> uterus <input type="checkbox"/> adnexa <input checked="" type="checkbox"/> CVA tenderness	more below <input type="checkbox"/>	<b>CRITICAL CARE TIME MUST BE DOCUMENTED</b> <input checked="" type="checkbox"/> CRITICAL CARE TIME BELOW DOES NOT INCLUDE TIME FOR SEPARATELY BILLED PROCEDURES. CRITICAL CARE Total Time _____ 30-74 minutes <input type="checkbox"/> 75-105 minutes <input type="checkbox"/>	
<b>Procedures</b> Location _____ Length _____ min. Layered Y/N _____ FB Y/N _____ Neur/vas/motor intact Y/N _____		<b>Additional documentation</b> CRK cardiomegaly no evidence of CHF per radiology (+2) very firm difficult to assess edema	

JEFFERSON HEALTH SYSTEM  
COOPER GREEN HOSPITAL  
EMERGENCY DEPARTMENT RECORD

HICKS, CHARLES  
00-33-63-34 09102004  
DOUYON, HUGUETTE  
M 42 11/02/61 S

Date 9/18/04

Name Charles E Hicks

Primary Diagnosis 1. MED 83585 33

Vital Signs BP

Allergies NKA

Pulse

Resp

Temp

Time Ordered

MED / FLUID / DOSE / ROUTE / RATE

Time Done

Nurse Initials

CBC 1835  
BMP 1835

830

BD

1830

BD

2015 IV cefazolin 0.2g po

2015 MW

THERAPEUTIC

Consultation: Dr. \_\_\_\_\_ Called \_\_\_\_\_ Ans \_\_\_\_\_ Arr \_\_\_\_\_ Dr. \_\_\_\_\_ Called \_\_\_\_\_ Ans \_\_\_\_\_ Arr \_\_\_\_\_

Initial Impression/Different Diagnosis

Additional history, exam, reassessments

Secondary Diagnosis

Secondary Diagnosis

Secondary Diagnosis

Secondary Diagnosis

CONDITION

DISPOSITION

☒ Stable ☐ Improved ☐ Discharge

☐ Exp.

☐ AMA

☒ DC

☐ Admit

☐ IP

☐ OB

☐ Transfer to

Notification: ☐ Family

☐ Police

☐ Coroner

Time

By

CERTIFIED MEDICAL EMERGENCY

☐ YES

☒ NO

Physician Signature  
Chart complete when checked

[Signature]

☐ NOTE  
DICTATED



**COOPER GREEN HOSPITAL  
EMERGENCY DEPARTMENT RECORD  
EMERGENCY SERVICES CARE PROTOCOLS**

HICKS, CHARLES  
00-33-63-34  
DOUYON, HUGUETTE  
42 11/02/61 S

keyplate

TIME \_\_\_\_\_ DATE \_\_\_\_\_

26836585

33

**CHEST PAIN**

- OLD CHART, CARDIAC MONITOR, SALINE LOCK
- STAT ECG
- CBC, CMP, CHEST PAIN PANEL, MG, PCXR
- PULSE OXIMETRY
- \_\_\_\_\_ O2 per \_\_\_\_\_
- UDS
- UCG IF INDICATED
- ASPIRIN 81MG TO CHEW IF NO ALLERGY
- NITROGLYCERIN 0.4 MG SL Q 5 MIN (IV SBP > 90)
- LABETOLOL 5 MG IV (IF SBP > 90)

**BRAIN ATTACK/  
ALTERED MENTAL STATUS**

- OLD CHART, CARDIAC MONITOR, SALINE LOCK, ECG, ACCUCHECK
- CBC, CMP, PTT, T4, TSH, B12, U/A, PCXR
- PULSE OXIMETRY
- \_\_\_\_\_ O2 per \_\_\_\_\_
- BRAIN CT
- UDS
- UCG IF INDICATED

**SUSPECTED OVERDOSE**

- OLD CHART, CARDIAC MONITOR, SALINE LOCK, ECG, ACCUCHECK
- CBC, CMP, ACETAMINOPHEN & \_\_\_\_\_
- SALICYLATE LEVEL
- ETOH LEVEL IF INDICATED
- PULSE OXIMETRY
- \_\_\_\_\_ O2 per \_\_\_\_\_
- UDS
- UCG IF INDICATED

**SOB/RESPIRATORY DISTRESS**

- OLD CHART, CARDIAC MONITOR, SALINE LOCK
- CBC, CMP, ABG (IF SAT < 90)
- UCG IF INDICATED
- PULSE OXIMETRY (O2 IF SAT < 90)
- \_\_\_\_\_ O2 per \_\_\_\_\_
- ALBUTEROL/ATROVENT NEBS Q 15 MIN X'S 3
- ECG
- SOLUMEDROL 125 MG IV
- BLOOD CULTURES X 2 BEFORE ANTIBIOTICS (IF TEMP > 100.6)
- ROCEPHIN 1 GM IV
- LEVAQUIN 500MG IV

**ETOH INTOXICATION**

- OLD CHART, SALINE LOCK
- CBC, CMP, ETOH, MG, ACCUCHECK
- IV FLUIDS WITH 1 AMP MV, FOLATE
- THIAMINE 150MG
- PULSE OXIMETRY (O2 IF SAT < 90)
- \_\_\_\_\_ O2 per \_\_\_\_\_
- UDS IF INDICATED
- UCG IF INDICATED

**GIBBLEE**

- OLD CHART, CARDIAC MONITOR
- CBC, CMP, PTT, U/A, PCXR
- TYPE AND SCREEN IF INDICATED
- UCG IF INDICATED
- IV FLUIDS NS @ \_\_\_\_\_ ML/HR
- NG TUBE IF INDICATED
- HEMOCULT STOOLS
- ABDOMINAL SERIES

**NEW ONSET SEIZURE**

- OLD CHART, CARDIAC MONITOR, SALINE LOCK
- CBC, BMP, CA, MG, ACCUCHECK
- UDS IF INDICATED
- ETOH IF INDICATED
- UCG IF INDICATED
- PULSE OXIMETRY (O2 IF SAT < 90)
- \_\_\_\_\_ O2 per \_\_\_\_\_
- BRAIN CT
- ATIVAN 2 MG FOR ACTIVE SEIZURES

**RESPIRATORY PRECAUTIONS**

- OLD CHART, CARDIAC MONITOR, SALINE LOCK, ECG
- IV FLUIDS NS @ \_\_\_\_\_ ML/HR
- CBC, RETICULOCYTE COUNT, CMP, UA
- UCG IF INDICATED
- PULSE OXIMETRY (O2 IF SAT < 90)
- \_\_\_\_\_ O2 per \_\_\_\_\_
- DILAUDID 2 MG IV

**FEVER > 100.6 IMMUNOCOMPROMISED/  
AGE 60 OR OLDER**

- OLD CHART, SALINE LOCK, PCXR
- CBC, CMP, UA, URINE C & S
- BLOOD CULTURES X 2 BEFORE ANTIBIOTICS (IF TEMP > 100.6)
- UCG IF INDICATED
- PULSE OXIMETRY (O2 IF SAT < 90)
- \_\_\_\_\_ O2 per \_\_\_\_\_
- ACETAMINOPHEN 650 MG PO OR RECTAL PRN FOR TEMP > 100.6

**SUSPECTED RENAL COLIC**

- OLD CHART, SALINE LOCK
- CBC, CMP, UA
- ABDOMINAL SERIES
- UCG IF INDICATED

**SUSPECTED PYLEONEPHRITIS**

- OLD CHART, SALINE LOCK
- CBC, CMP, UA, URINE, C & S
- UCG IF INDICATED
- ACETAMINOPHEN 650 MG PO OR RECTAL PRN FOR TEMP > 100.6

**LOWER ABD PAIN/  
VAGINAL BLEEDING**

- OLD CHART, SALINE LOCK
- CBC, CMP, UA
- UCG IF INDICATED
- SERUM QUANT. HCG IF UCG POSITIVE
- TYPE & RH IF PREGNANT AND BLEEDING
- ABDOMINAL SERIES
- ACETAMINOPHEN 650 MG PO OR RECTAL PRN FOR TEMP > 100.6

**EXTREMITY INJURY**

- SALINE LOCK
- IMMOBILIZE/ELEVATE EXTREMITY
- APPLY COLD COMPRESS IF INJURY < 48 HRS
- OLD
- TETANUS TOXOID, 0.5 ML IM IF INDICATED
- X-RAY
- UCG IF INDICATED

**SUSPECTED HIP FRACTURE**

- SALINE LOCK
- CBC, CMP, UA
- X-RAY □ R HIP □ L HIP
- X-RAY
- UCG IF INDICATED

**LACERATIONS**

- CLEAN WOUND WITH SALINE
- X-RAY IF FOREIGN BODY/FRACTURE SUSPECTED
- X-RAY
- TETANUS TOXOID, 0.5 ML IM IF INDICATED
- SUTURE SETUP

**MEDICAL CLEARANCE FOR  
PSYCHIATRIC EVALUATION**

- CBC, BMP
- ETOH
- UDS
- UCG IF INDICATED

**THERAPEUTIC LEVELS WHEN INDICATED**

- DIGOXIN
- THEOPHYLLINE
- DILANTIN
- PHENOBARBITAL
- PROTIME (PT) / INR

MD SIGNATURE \_\_\_\_\_

RN SIGNATURE \_\_\_\_\_

CHURCH SIGNATURE \_\_\_\_\_

- Done without MD order
- Requires Physician order

JEFFERSON HEALTH SYSTEM  
COOPER GREEN HOSPITAL  
EMERGENCY DEPARTMENT RECORD

HICKS, CHARLES  
00-33-63-34  
DOUYON, HUGUETTE 102004  
42 11/02/61 S

26836585

33

## Chief complaint:

*He presents today for my refills.  
States w/o any of his meds x 7 years.  
He denies any other symptoms*

Time seen  
by physician☐ Symptom/Location☐ Severity☐ Modifying Factors☐ Context/Mechanism of injury☐ Quality☐ Duration☐ Timing☐ Associated Signs & Sx☐ EMS Direction

Level 1, 2, 3 Documentation - 1 system, problem pertinent

Level 4 Documentation - 2 to 3 systems

Pain Severity 0 - 1 - 2 - 3 - 4 - 5 (Circle One)

Level 5 Documentation - 10+ systems

☒ All systems negative except as noted☐ Unable to fully assess due to:

() altered LOC () pallent condition () other

☒ All normal

Circle positive

fever chills high BP  
weight loss dizzy weak  
activity poor feeding swants

redness discharge visual loss  
pain blurred vision change

wore throat nosebleeds rhinorrhea  
hoarse throat swelling hearing loss  
otalgia drooling

chest pain rapid ht beat LE edema  
palpitations slow ht beat orthopnea  
PND

SOB prod. cough DOE  
pleuritic CP nonprod. cough  
hemoptysis croupy cough

nausea diarrhea pain  
vomiting constipation bloating  
melena jaundice blood in stool

dysuria discharge dyspareunia  
frequency irreg menses flank pain  
hematuria urine output post UTI  
myalgias neck/back pain radnoes  
arthralgias inflammation heat  
limping previous injury

rash bruising contusions  
swelling lacerations abrasions

headache numbness change funct  
weakness change LOC paresthesias  
change speech developmental delay

change MS agitation suicidal  
confusion depression hostile  
memory loss

fatigue polyuria hair change  
weakness polydipsia heat tolerance

bleeding nodos  
bruising petechiae

rhinorrhea alopic dermat.  
asthma strabismic  
itchy eyes

## RISK FACTORS

Age &gt; 35 years

CAD

HTN

DM

Family H/O CAD/MI

Menopause

Bilateral Oophorectomy

Cocaine within 1 week

Tobacco use

CA

CVA

Asthma

Pedal edema

DM

CAD

Tobacco

Substance

Lives Alone

Marital Status

5

Lives Alone

## ALLERGIES &amp; MED'S

See Attached Notes.

See Attached Notes.



JEFFERSON HEALTH SYS. -M  
COOPER GREEN HOSPITAL  
EMERGENCY DEPARTMENT RECORD

HICKS, CHARLES  
00-33-63-34 09102004  
DOUYON, HUGUETTE  
M 42 11/02/61 S

26836585

Level 2, 3 - 2 to 4 body areas / organ systems		All elements not circled/struck/checked/annotated - were not pertinent		Level 4 - 5 to 7 body areas / organ systems		Level 5 - 8 or more organ systems	
<b>Physical Examination</b>							
Physical Examination incomplete due to critical condition of patient.							
C O N S	<input checked="" type="checkbox"/> Vital signs per nurses notes <input type="checkbox"/> Well developed, well nourished <input type="checkbox"/> No acute pain/distress <input type="checkbox"/> No Odor ETOH			<input checked="" type="checkbox"/> Normal <input checked="" type="checkbox"/> <u>circled</u> positives and provide additional documentation			
	<input checked="" type="checkbox"/> Alert and oriented to TYP <input type="checkbox"/> No abnormalities of mood or affect <input type="checkbox"/> Memory (recent and remote) intact <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed <input type="checkbox"/> Suicidal			<input type="checkbox"/> No adenopathy of neck <input type="checkbox"/> No adenopathy of axillae <input type="checkbox"/> No adenopathy of groin <input type="checkbox"/> No adenopathy, other			
	<input type="checkbox"/> PERAL <input checked="" type="checkbox"/> Conjunctivae and lids normal <input checked="" type="checkbox"/> Fundi and discs normal <input checked="" type="checkbox"/> EOM normal			<input type="checkbox"/> Normal gait and station <input type="checkbox"/> Normal digits and nails <input type="checkbox"/> Muscle atrophy <input type="checkbox"/> Neurovascular status intact			
	<input type="checkbox"/> Otolaryngeal exam of external canal and TMs normal <input type="checkbox"/> Nasal mucosa, turbinates, and septum normal <input checked="" type="checkbox"/> Mouth, tongue, and pharynx normal <input type="checkbox"/> Pharynx without edema, exudate, or injection			<input type="checkbox"/> Normal to inspection <input type="checkbox"/> Normal to palpation			
E N T	<input type="checkbox"/> Neck supple <input type="checkbox"/> No JVD <input type="checkbox"/> No thyromegaly <input type="checkbox"/> No bruits			<input type="checkbox"/> No masses or tenderness <input type="checkbox"/> Breasts symmetric <input type="checkbox"/> No discharge			
	<input checked="" type="checkbox"/> Normal respiratory effort and excursion <input type="checkbox"/> No rales, rhonchi or wheezes <input type="checkbox"/> Normal to percussion <input type="checkbox"/> Equal air entry			<input checked="" type="checkbox"/> Glasgow Coma Scale Initial _____ Repeat _____			
N E C K	<input type="checkbox"/> Normal PMI with no thrills, RSR <input type="checkbox"/> No murmurs or gallops <input type="checkbox"/> Normal Lungs <input type="checkbox"/> No edema or varicosities			<input type="checkbox"/> normal abd aorta <input type="checkbox"/> normal femora <input type="checkbox"/> normal pedals			
	<input checked="" type="checkbox"/> Normal speech <input type="checkbox"/> CN II-XII intact <input type="checkbox"/> DTRs normal, no pathologic reflexes <input type="checkbox"/> Normal motor and sensory function <input type="checkbox"/> No ataxia <input type="checkbox"/> Normal cerebellar <input type="checkbox"/> Normal Romberg			<input type="checkbox"/> No masses, tenderness, rebound or guarding <input type="checkbox"/> Normal liver, spleen, kidney <input type="checkbox"/> No hernia <input type="checkbox"/> Rectal, not indicated <input type="checkbox"/> rectal normal <input type="checkbox"/> hemoccult negative/positive <input type="checkbox"/> Normal bowel sounds			
R E S P	<input type="checkbox"/> Genitalia normal to inspection <input type="checkbox"/> No masses, tenderness or adenopathy <input type="checkbox"/> Genitalia normal to palpation <input type="checkbox"/> Normal cervix <input type="checkbox"/> Normal bimanual <input type="checkbox"/> bladder <input type="checkbox"/> uterus <input type="checkbox"/> adnexa <input type="checkbox"/> CVA tenderness			<input type="checkbox"/> Additional documentation			
	<input type="checkbox"/> Genitalia normal to inspection <input type="checkbox"/> No masses, tenderness or adenopathy <input type="checkbox"/> Genitalia normal to palpation <input type="checkbox"/> Normal cervix <input type="checkbox"/> Normal bimanual <input type="checkbox"/> bladder <input type="checkbox"/> uterus <input type="checkbox"/> adnexa <input type="checkbox"/> CVA tenderness			<input type="checkbox"/> Additional documentation			
G I	<input type="checkbox"/> Genitalia normal to inspection <input type="checkbox"/> No masses, tenderness or adenopathy <input type="checkbox"/> Genitalia normal to palpation <input type="checkbox"/> Normal cervix <input type="checkbox"/> Normal bimanual <input type="checkbox"/> bladder <input type="checkbox"/> uterus <input type="checkbox"/> adnexa <input type="checkbox"/> CVA tenderness			<input type="checkbox"/> Additional documentation			
	<input type="checkbox"/> Genitalia normal to inspection <input type="checkbox"/> No masses, tenderness or adenopathy <input type="checkbox"/> Genitalia normal to palpation <input type="checkbox"/> Normal cervix <input type="checkbox"/> Normal bimanual <input type="checkbox"/> bladder <input type="checkbox"/> uterus <input type="checkbox"/> adnexa <input type="checkbox"/> CVA tenderness			<input type="checkbox"/> Additional documentation			
G U	<input type="checkbox"/> Genitalia normal to inspection <input type="checkbox"/> No masses, tenderness or adenopathy <input type="checkbox"/> Genitalia normal to palpation <input type="checkbox"/> Normal cervix <input type="checkbox"/> Normal bimanual <input type="checkbox"/> bladder <input type="checkbox"/> uterus <input type="checkbox"/> adnexa <input type="checkbox"/> CVA tenderness			<input type="checkbox"/> Additional documentation			
	<input type="checkbox"/> Genitalia normal to inspection <input type="checkbox"/> No masses, tenderness or adenopathy <input type="checkbox"/> Genitalia normal to palpation <input type="checkbox"/> Normal cervix <input type="checkbox"/> Normal bimanual <input type="checkbox"/> bladder <input type="checkbox"/> uterus <input type="checkbox"/> adnexa <input type="checkbox"/> CVA tenderness			<input type="checkbox"/> Additional documentation			

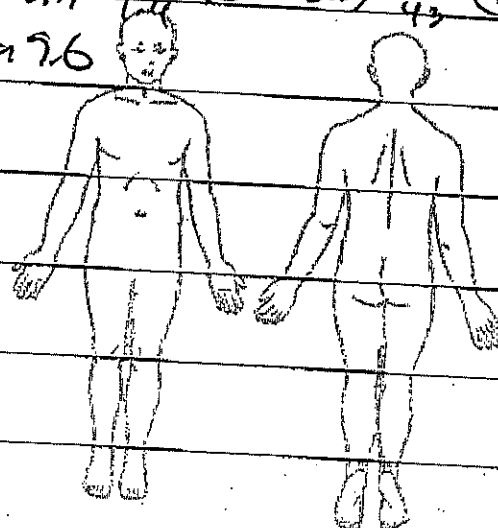
**CRITICAL CARE TIME MUST BE DOCUMENTED**

☒ CRITICAL CARE TIME BELOW DOES NOT INCLUDE TIME FOR SEPARATELY BILLED PROCEDURES.

CRITICAL CARE Total Time \_\_\_\_\_ 30-74 minutes ☐ 75-106 minutes ☐

Additional documentation

140 (105) 14 (113) 5.2 14.7 (29)  
4.3 28.9 4.3  
Ca 9.6



NAME HICKS, CHARLES		SEX M	ACCOUNT NUMBER 27066679
ORDERING PHYSICIAN PERRY, JACQUILINE T.		PT. STATUS UNK	MEDICAL RECORD NO. 00336334
ATTENDING PHYSICIAN	DATE OF BIRTH 11/02/1961	AGE 44	DATE OF EXAM 10/19/2004
			RADIOLOGY NO. 00077441

EXAM#	TYPE/EXAM	RESULT
000451974	DXER/CHEST, TWO VIEWS, FRONT &	

PA AND LATERAL CHEST: Negative study.

\*\* REPORT SIGNATURE ON FILE 10/20/2004 \*\*  
Reported By: William P. Cason, M.D.  
Signed By: Dr. William Cason

CC: PERRY, JACQUILINE T.

Technologist: JESSIE M. CALHOUN  
Transcribed Date/Time: 10/19/2004 (1541)  
Transcriptionist: SMOVE  
Printed Date/Time: 05/19/2006 (1454)

PAGE 1

ADDENDUM Printed From PCI

RUN DATE: 05192006

RUN TIME: 1454

RUN USER: BROHE

Cooper Green Hospital

\*LIVE\*

PAGE 1

Summary Discharge Report

LOCATION

PATIENT: <b>HICKS, CHARLES</b>	ACCT #: 26836585	LOC: ER	U #: 00336334
REG DR: DOUTON, HUGUETTE	AGE/SX: 42/M	ROOM:	REG: 09102004
	STATUS: DEP ER	BED:	DIS:

## General Chemistry

## \* \* \* \* \* Chemistry Section \* \* \* \* \*

Day	Date	Time	Na (136-148) MMOL/L	K (3.6-5.2) MMOL/L	Cl (98-108) MMOL/L	CO2 (21-32) MMOL/L	BUN (7-18) MG/DL
=>	1	SEP 10	1835	140	4.3	105	25.7

Day	Date	Time	Gluc (70-110) MG/DL	Crea (0.6-1.3) MG/DL	ANION (9-16) MMOL/L	BUN/CREAT (12-22) RATIO	Ca (8.7-10.2) MG/DL
=>	1	SEP 10	1835	1.3 H	1.4 H	13.60	10.00 L

Patient: <b>HICKS, CHARLES</b>	Age/Sex: 42/M	Acct#26836585	Unit#00336334
--------------------------------	---------------	---------------	---------------

RUN DATE: 05192006  
RUN TIME: 1454  
RUN USER: BROHE

Cooper Green Hospital  
Summary Discharge Report

PAGE 2

LOCATION

Patient: HICKS, CHARLES

#26836585

(Continued)

Complete Blood Count

Hematology Section

Day	Date	Time	WBC (4.3-10.8) TH/uL	RBC (4.2-6.1) MIL/uL	HGB (13.0-18.0) g/dL	HCT (43-52) %	MCV (80-98) fL	
=>	1	SEP 10	1835	5.2	5.01	14.7	43.2	86.3

Day	Date	Time	MCH (27-32) pg	MCHC (32-37) g/dL	RDW (11.5-14.5) UNITS	PLT (140-440) TH/uL	MPV (7.4-10.4) fL	
=>	1	SEP 10	1835	29.3	34.0	14.1	298	7.8

Patient: HICKS, CHARLES

Age/Sex: 42/M

Acct#26836585

Unit#00336334

JEFFERSON HEALTH SYSTEM  
COOPER GREEN HOSPITAL  
EMERGENCY DEPARTMENT RECORD

Date

Name

Primary Diagnosis

Vital Signs

Allergies

Time Ordered

Pulse

Resp

Temp

MED / FLUID / DOSE / ROUTE / RATE

Time Done

Nurse Initials

① Clonidine 0.2mg po q100  
② old records  
③ CXR PA+LAF

1310

JB

1310 Repeat B/P 194/121 66  
TED NOSE knee high

1310

JB

1450 BP 139/92 P65 R18

1500

JB

1600

JB

THERAPEUTIC

Consultation: Dr.

Initial Impression/Different Diagnosis

Called Ans Arr Dr.

Additional history, exam, reassessments

Called Ans Arr

HTN / Diabetes / peripheral edema

Secondary Diagnosis

Secondary Diagnosis

Secondary Diagnosis

Secondary Diagnosis

CONDITION

☐ Stable ☐ Improved ☐ Disc.

Notification: ☐ Family ☐ Police

☐ Exp.

☐ AMA

☐ DC

☐ Admit

☐ IP

☐ OB

☐ Transfer to

☐ Coroner

Time

By

CERTIFIED MEDICAL EMERGENCY  
☐ YES ☐ NO

Physician  
☐ Signature  
Chart complete when checked

Ryan White

NOTE  
DICTATED

# EXHIBIT B



IN THE UNITED STATES DISTRICT COURT  
FOR THE MIDDLE DISTRICT OF ALABAMA  
NORTHERN DIVISION

CHARLES HICKS (# 246241)

\*

Plaintiff,

\*

v.

\*

2:06-CV-1033-WKW

\*

RICHARD ALLEN, et al.

\*

Defendants.

\*

**AFFIDAVIT OF PAUL CORBIER, M.D.**

STATE OF ALABAMA

COUNTY OF Elmore

BEFORE ME, Charles Paul Minor, a notary public in and for said County and State, personally appeared **PAUL CORBIER, M.D.** and being duly sworn, deposed and says on oath that the averments contained in the foregoing are true to the best of her ability, information, knowledge and belief, as follows:

My name is Paul Corbier. I am over the age of twenty-one and am personally familiar with all of the facts set forth in this Affidavit. I have been licensed as a physician in Alabama since 2005, and have been board certified in internal medicine since 1998. I have served as the Medical Director for Staton Correctional Facility in Elmore, Alabama since July 2006. I also provide treatment to inmates at Frank Lee Youth Center in Deatsville, Alabama that are brought to Staton Correctional Facility. Since July 2006 my employment at Staton Correctional Facility has been with Prison Health Services, Inc. ("PHS"), the company which currently contracts with the Alabama Department of Corrections to provide medical services to inmates.

Charles Hicks (#246241) is an inmate who was incarcerated at Frank Lee Youth Center and treated at Staton Correctional Facility at all times relevant to this matter. I have reviewed Mr. Hicks' Complaint in this action as well as his medical records (certified copies of which are being produced to the Court along with this Affidavit).

It is my understanding that Mr. Hicks has made a Complaint in this matter that Frank Lee Youth Center has failed to provide him with appropriate medical treatment between April 2006 and October 19, 2006. Mr. Hick's allegations are unfounded, as this inmate has been provided appropriate care at all times.

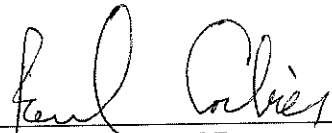
Mr. Hicks has a medical history of Diabetes and swelling in his left leg with venous insufficiency. His Diabetes is a hereditary condition. He has circulatory problems which are complicated by problems with his feet. His condition can be treated by controlling his Diabetes and swelling in his left leg, but there is no cure. Mr. Hicks has been treated at Staton Correctional Facility for these problems with medication, blood tests, diagnostic studies and TED hose. Mr. Hicks requested diabetic shoes and his request was submitted to the proper authorities. His request was denied due to his lack of meeting the proper criteria. I have since re-evaluated Mr. Hicks and resubmitted his request based on additional information I obtained. He has been treated each time he raised any health complaints.

Based on my review of Hicks' medical records, and on my personal knowledge of the treatment provided to him, it is my opinion that all of his medical conditions and complaints have been evaluated in a timely fashion at Staton Correctional Facility, and that his diagnosed conditions have been treated in a timely and appropriate fashion. At all times, he has received appropriate medical treatment for his health conditions from me and the other PHS personnel at Staton Correctional Facility. At no time has he been denied any needed medical treatment. In

other words, it is my opinion that the appropriate standard of care has been adhered to at all times in providing medical care, evaluation, and treatment to this inmate.

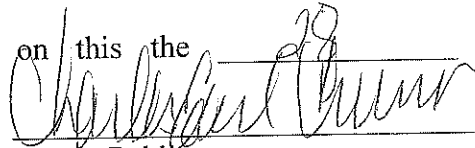
At no time have I or any of the medical or nursing staff at Staton Correctional Facility denied Hicks any needed medical treatment, nor have we ever acted with deliberate indifference to any serious medical need of Hicks. At all times, Hicks' known medical complaints and conditions have been addressed as promptly as possible under the circumstances.

Further affiant sayith not.

  
\_\_\_\_\_  
PAUL CORBIER, M.D.

STATE OF ALABAMA )

COUNTY OF Shuford )

Shuford Sworn to and subscribed before me on this the 29 day of March, 2007.  
  
\_\_\_\_\_  
Notary Public

My Commission Expires:

4/10/2010

# EXHIBIT C

IN THE DISTRICT COURT OF THE UNITED STATES  
FOR THE MIDDLE DISTRICT OF ALABAMA  
NORTHERN DIVISION

CHARLES HICKS, (AIS #246241),

\*

\*

Plaintiff,

\*

V.

2:06-CV-1033-WKW

\*

RICHARD ALLEN, et al.

\*

Defendants.

\*

**AFFIDAVIT OF DARRYL ELLIS, DIRECTOR OF NURSING**

BEFORE ME, Annie Ladimore a notary public in and for said County and State, personally appeared **DARRYL ELLIS, DIRECTOR OF NURSING**, and being duly sworn, deposed and says on oath that the averments contained in the foregoing are true to the best of her ability, information, knowledge and belief, as follows:

“My name is Darryl Ellis. I am over the age of twenty-one and am personally familiar with all of the facts set forth in this Affidavit. I have been a licensed, registered nurse in Alabama since 1995. I hold an Associates Degree in nursing from Troy State University. Since 1995, I have practiced as a registered nurse in a variety of positions and settings. In particular, I have worked at Staton Correctional Facility in Elmore, Alabama as a LPN since 1985 and as a registered nurse since 1995. Staton Correctional Facility also provides treatment to inmates at Frank Lee Youth Center in Deatsville, Alabama. Since October 2005, I have been employed as the Director of Nursing for Staton Correctional Facility by Prison Health Services, Inc., the company which currently

contracts with the Alabama Department of Corrections to provide medical services to inmates.

Prison Health Services, Inc. (PHS) has established a simple three-step procedure for identifying and addressing inmate grievances at Frank Lee Youth Center. If an inmate has a grievance regarding a healthcare issue he must submit to the healthcare unit a "Medical Complaint Form." These are standard forms that may be requested from an inmate's supervising officer in his dormitory. The inmate medical complaint form allows an inmate to communicate any healthcare related concern by placing the medical complaint form in the sick call box or mailbox to be forwarded to the healthcare unit. I subsequently review the request and respond accordingly via in-house mail. Also, when deemed necessary, the inmate will receive a face-to-face interview with me or the doctor or both. At this time, the needs of the inmate are addressed and treatment is discussed.

If an inmate is unsatisfied with my response, he may request an "Inmate Formal Grievance" form from the healthcare unit. This form allows an inmate to again voice his concerns relating to the healthcare issue addressed with the medical complaint form. I again respond to the inmate via in-house mail.

If the inmate is still unsatisfied with my response, he or she may request from the healthcare unit an "Inmate Grievance Appeal" form. This form is again submitted to me and represents the final step of the appeal process. After an inmate submits an inmate grievance appeal, I will meet with the inmate face-to-face in a final attempt to address his concerns verbally.

It is my understanding that Charles Hicks has filed suit in this matter alleging that PHS has failed to provide him with appropriate medical treatment between April 2006



and October 19, 2006. However, Mr. Hicks has failed to exhaust Frank Lee's informal grievance procedure relating to the receipt of medical care for this alleged condition. Specifically, Mr. Hicks has not submitted all appropriate and required forms. As such, the healthcare unit at Frank Lee Youth Center (Staton Correctional Facility) has not been afforded the opportunity to resolve Mr. Hick's medical complaints prior to filing suit.

Further affiant sayeth not.

Darryl Ellis  
DARRYL ELLIS  
DIRECTOR OF NURSING

STATE OF ALABAMA                    )  
COUNTY OF Elmore                )

Sworn to and subscribed before me on this the 26 day of  
February 2007.

Annie Statmore

Notary Public

My Commission Expires:

12/06/2008

# **EXHIBIT D**

Case 2:06-cv-00990-MEF-CSC Document 1 Filed 11/01/2006 Page 1 of 4  
IN THE UNITED STATES DISTRICT COURT FOR  
THE MIDDLE DISTRICT OF ALABAMA

Charles Hicks # 246241 )  
Full name and prison number )  
of plaintiff(s) ) 2006 NOV -1 A 11:05

v. )  
DEBRA P. HACKE ) CIVIL ACTION NO. 2:06CV990-MEF  
U.S. DISTRICT COURT ) (To be supplied by Clerk of  
U.S. District Court)

ALABAMA DEPARTMENT OF CORRECTIONS )  
ET AL And Prison Medical )  
SERVICES 416 Mary Lindsay )  
Park Dr, Suite 515, Franklin )  
TN 37067 )

Name of person(s) who violated )  
your constitutional rights. )  
(List the names of all the )  
persons.) )

I. PREVIOUS LAWSUITS

- A. Have you begun other lawsuits in state or federal court dealing with the same or similar facts involved in this action? YES ( ) NO ( ☒ )
- B. Have you begun other lawsuits in state or federal court relating to your imprisonment? YES ( ) NO ( ☒ )
- C. If your answer to A or B is yes, describe each lawsuit in the space below. (If there is more than one lawsuit, describe the additional lawsuits on another piece of paper, using the same outline.)

1. Parties to this previous lawsuit:

Plaintiff(s) N/A

Defendant(s) N/A

2. Court (if federal court, name the district; if state court, name the county) N/A

Case 2:06-cv-00990-MEF-CSC Document 1 Filed 11/01/2006 Page 2 of 4

3. Docket number N/A
4. Name of judge to whom case was assigned N/A
5. Disposition (for example: Was the case dismissed? Was it appealed? Is it still pending?) N/A
6. Approximate date of filing lawsuit N/A
7. Approximate date of disposition N/A

II. PLACE OF PRESENT CONFINEMENT FRANK LEE YOUTH CENTER  
P.O. B. 220410, DEATSVILLE, AL 36022  
 PLACE OF INSTITUTION WHERE INCIDENT OCCURRED FRANK LEE YOUTH  
Center

III. NAME AND ADDRESS OF INDIVIDUAL(S) YOU ALLEGE VIOLATED YOUR CONSTITUTIONAL RIGHTS.

NAME	ADDRESS
1. <u>Commissioner Richard Allen ET, AL</u>	<u>1400 LLOYD ST. MONTGOMERY, AL 36107</u>
2. <u>Dr. Corbier ET, AL, Prison Medical Services</u>	<u>416 Mary Lindsay, PK. Dr.</u> <u>Suite 315</u> <u>FRANKLIN, TN 37067</u>
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

IV. THE DATE UPON WHICH SAID VIOLATION OCCURRED April - 2006  
thru OCTOBER 19, 2006

V. STATE BRIEFLY THE GROUNDS ON WHICH YOU BASE YOUR ALLEGATION THAT YOUR CONSTITUTIONAL RIGHTS ARE BEING VIOLATED:

GROUND ONE: To Provide ADEQUATE MEDICAL TREATMENT

Case 2:06-cv-00990-MEF-CSC Document 1 Filed 11/01/2006 Page 3 of 4  
 STATE BRIEFLY THE FACTS WHICH SUPPORT THIS GROUND. (State as best you can the time, place and manner and person involved.)

I am a diabetic and have been incarcerated since April, 2000. Since that time the MA, Dept of Corr, and Prison Medical Services, has not provided me with ADEQUATE Medical Treatment. As of this moment my left leg is swollen to the bursting stage. I cannot wear a shoe on my feet or hardly walk. This Administration has done nothing to treat the illness adequately.

This Administration has not provided me with Adequate Eye Care, Adequate Diabetic Meals. I have repeatedly requested Adequate Medical Treatment. But my request have been ignored by the Medical Service, that provide Medical Services to Prisoners. The defendants owe me this and Adequate Medical Care. They have breached this duty. And the breach has caused me harm. By their continuing negligence of the matter this has continued for a period of 7 months. I have filed numerous Grievances, but nothing has been done. I have complained to both chain of Command. But only to be ignored, My condition is worsen and I am in constant pain. And I fear that I may have to have my Left Leg Amputated because of this continued negligence.

Case 2:06-cv-00990-MEF-CSC Document 1 Filed 11/01/2006 Page 4 of 4

VI. STATE BRIEFLY EXACTLY WHAT YOU WANT THE COURT TO DO FOR YOU.  
MAKE NO LEGAL ARGUMENT. CITE NO CASES OR STATUTES.

I want to receive Adequate Medical treatment, And to be seen by  
and outside Physician, Immediately want to be Attended to by a  
Medical Specialist in this Area of Care.

Charles Hicks  
Signature of plaintiff(s)

I declare under penalty of perjury that the foregoing is true  
and correct.

EXECUTED on 10/19/06  
(Date)

Charles Hicks  
Signature of plaintiff(s)



# EXHIBIT E

Case 2:06-cv-01033-WKW-CSC Document 1 Filed 11/17/2006 Page 1 of 4

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF ALABAMA

RECEIVED

2006 NOV 17 A 9:49

2:06CV1033-WKW

Inmate Identification Number: #246244  
DEBRA P. HACKETT CLERK  
U.S. DISTRICT COURT  
MIDDLE DISTRICT ALA

Charles Hicks

(Enter above the full name(s) of the plaintiff(s)  
in this action)

vs.

"Alabama Department of Corrections"

"Frank Lee Youth Center"

(Enter above full name(s) of the defendant(s)  
in this action)

NOTICE TO FILING PARTY

It is your responsibility to  
notify the clerk in writing  
of any address change.  
Failure to notify the clerk  
may result in dismissal  
of your case  
without further notice.

I. Previous lawsuits

A. Have you begun other lawsuits in state or federal court(s) dealing with the same facts involved in this action or otherwise relating to your imprisonment?  
Yes ( ☒ ) No ( ☐ )

B. If your answer to (A) is "yes," describe each lawsuit in the space below. (If there is more than one lawsuit, describe the additional lawsuit(s) on another piece of paper, using the same outline.)

1. Parties to this previous lawsuit:

Plaintiff(s):

Charles Hicks

Defendant(s):

Alabama Department of Corrections, Commissioner Richard Allen etc, Alabama Prison Medical Services

Case 2:06-cv-01033-WKW-CSC Document 1 Filed 11/17/2006 Page 2 of 4

2. Court (if Federal Court, name the district; if State Court, name the county)

In the District Court of the United States for the Middle District of Ala.

3. Docket number 2:06-CV-990 MEF

4. Name of judge to whom case was assigned

Charles S. Goody

5. Disposition (for example: Was the case dismissed? Was it appealed? Is it still pending?) It is still pending

6. Approximate date of filing lawsuit October 19<sup>th</sup> 2006

7. Approximate date of disposition November 6<sup>th</sup> 2006

- I. Place of present confinement

Frank Lee Youth Center

- A. Is there a prisoner grievance procedure in this institution?

Yes ( ☒ ) No ( ☐ )

- B. Did you present the facts relating to your complaint in the state prisoner grievance procedure?

Yes ( ☒ ) No ( ☐ )

- C. If your answer is YES:

1. What steps did you take?

(1) notified an officer (2) Brought it to the Captains attention (3) Spoke with the Warden (Cummins).

2. What was the result?

The Warden set up an doctors appointment in which I did receive an ultra sound.

- D. If your answer is NO, explain why not?

N/A

## I. Parties

In item (A) below, place your name(s) in the first blank and place your present address in the second blank. Do the same for additional plaintiffs, if any.

A. Name of plaintiff(s) Charles Hicks

Address FLYC P.O. Box 220410 Deatsville, Ala 36022

In item (B) below, place the full name of the defendant in the first blank, his official position in the second blank, and his place of employment in the third blank. Use item (C) for the names, positions, and places of employment of any additional defendants.

B. Defendant Alabama Dept. of Correction etc. Richard Allen  
is employed as Commissioner

at Alabama Dept. of Corrections in Montgomery, Alabama

C. Additional Defendants Prison Medical and Health Services  
416 Mary Lindsay Park Drive Suite 515  
Franklin, Tennessee 37067

## V. Statement of Claim

State here, as briefly as possible, the FACTS of your case. Describe how each defendant is involved. Include also the names of other persons involved, dates and places. Do not give any legal arguments or cite any cases or statutes. If you intend to allege a number of related claims, number and set forth each claim in a separate paragraph. Use as much space as you need. Attach extra sheets, if necessary.

I am a diabetic and have been incarcerated since April, 2006. Since that time the Ala Dept. of Corr, and Prison Medical Services has not provided me with adequate medical treatment. My left leg is swollen and so badly that I cant wear an shoe, I can hardly walk. This admin. has done nothing to treat this illness adequately. I have constantly written medical requests to see the doctor but all of my requests have been ignored by the Professional medical

Case 2:06-cv-01033-WKW-CSC Document 1 Filed 11/17/2006 Page 4 of 4

here at Frank Lee Youth Center, that suppose to provide medical treatment to all prisoners. The defendants owe me this adequate medical treatment. They have breached their duty and caused me enormous amounts of physical pain, due to the lack of attention. This has been an on going affliction for the past 7 months, I have filed numerous grievances, but nothing has been done. I have went through the chain of command to only get ignored. My condition has worsen, and I'm in constant pain. I fear that I may have to have my leg amputated because of this continued negligence.

RELIEF

State briefly exactly what you want the court to do for you. Make no legal arguments. Cite no cases or statutes.

I want to sue the Dept. of Corrections of Alabama "Richard Allen" for neglect and cruel unusual punishment. I would also like to receive adequate medical treatment, and be seen by an outside physician, "Immediately".

"I declare under penalty of perjury that the foregoing is true and correct.

Executed on November 14<sup>th</sup>, 2006

Charles Hicks #246241 pro-se

FLYC dorm 3 bed 12

P.O. Box 220410

Deatsville, Ala 36022

Charles Hicks

Signature(s)

# EXHIBIT F





**PRISON HEALTH SERVICES, INC.  
SICK CALL REQUEST**

Print Name: Charles Hicks Date of Request: 8/2/06  
 ID # 246241 Date of Birth: 11-2-61 Location: 2 Dorm/BED 20  
 Nature of problem or request: I need to see a doctor real  
bad because i am not feeling well at  
all, as soon as possible. I am having trouble  
with my left shoulder, and my diabetes and blood  
Charles Hicks Presu  
 Signature

**DO NOT WRITE BELOW THIS LINE**

Date:    /   /     
 Time:     AM PM  
 Allergies:    

<b>RECEIVED</b> Date: <u>8/2/06</u> Time: <u>10:44pm</u> Receiving Nurse Initials <u>JP</u>
--

**(S)ubjective:**

**(O)bjective**

**(A)ssessment:**

**(P)lan:**

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN  
 CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

# **EXHIBIT G**

PHS

## Nursing Evaluation Tool

General Sick Call

Facility: Alabama Department of Corrections	
Patient Name: <u>Hickman</u>	<u>Charles</u>
Inmate Number: <u>246241</u>	Date of Birth: <u>11/2/61</u>
Date of Report: <u>8/23/06</u>	Time Seen: <u>12:30</u> AM/PM <u>PM</u> Circle One

**Subjective:** Chief Complaint(s): Came Back Monday from Court in Jefferson  
 Onset: County Have not had any medicine since  
 Brief History: Sunday. I get Diabetic medicine, Lasix, & BP  
 (Continue on back if necessary) medicines, Aspirin. I would like my  
medications restarted.

☐ Check Here if additional notes on back

**Objective:** Vital Signs: (As Indicated) T: 98.1 P: 72 RR: 12 B/P: 142/86

Examination Findings: On exam calm, oriented, cooperative.  
 (Continue on back if necessary)

☐ Check Here if additional notes on back
**Assessment: (Referral Status)**

Preliminary Determination(s):

☒ Referral NOT REQUIRED

☒ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other:

*pre note on Aug MAR in MAR Book to give meds from KOP stocks until arrival.*

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

**Plan:** Check All That Apply:
☒ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other:

OTC Medications given ☐ NO ☐ YES (If Yes List):

Referral: ☒ NO ☐ YES (If Yes, Whom/Where):

Date for referral: 1/1 1 my

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?):

Time:

Nurses Signature: [Signature]

Name:

Printed:

# EXHIBIT H

12/05/2006 15:12 FAX 95677167

STATON

002

<b>POLICY/PROCEDURE</b> Prison Health Services, Inc	Date of Origin: 11/03/03 Date of Previous: Revised Date: 1/1/05 Revised Date: 5/18/05  Page 1 of 1
FACILITY NAME: Alabama Department of Corrections	COUNTY: STATE: Alabama

TITLE: Grievance Mechanism for Health Complaints

NUMBER: GP011

REFERENCE: NCCHC : P-A-11; ACA Standard 1-HC-3A-01

**POLICY:**

It is the policy of PHS to encourage the resolution of inmate concerns regarding the health care system prior to the documentation of a written grievance. A grievance mechanism addresses inmate's complaints about health services.

**PROCEDURE:**

1. The Health Administrator will work with the facility administrator to ensure that there is a well-defined procedure for handling inmate grievances and appeals.
2. When a grievance about health care services is received (inmate grievance), the medical record is reviewed, and if necessary, the inmate is interviewed. A review of the grievance occurs within 3 days after receiving the grievance and answered.
3. Immediate resolution is expected if the grievance involves the inmate's access to health care. The Warden or Warden's designee will be copied.
4. Every effort will be made to resolve the inmate's grievance to his/her satisfaction.
5. If the grievance cannot be resolved to the inmate's satisfaction, the inmate may request an appeal in which case the written grievance will be reviewed through the facility review process and answered within 5 days.
6. Separate logs will be maintained for grievances and grievance appeals.
7. Summary review of inmate health care (grievances and grievance appeal logs) are included in the Quality Improvement meetings and identified problems are viewed as opportunities to improve care.